HARVARD MEDICAL

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Editor's note: The mysterious Brigham and Women's Hospital mentioned several times on the succeeding pages, is merely the latest incarnation of the Affiliated Hospitals Center, formed by the now-famous merger of the Peter Bent Brigham and Robert Breck Brigham hospitals and the two divisions of the Boston Hospital for Women. The BHW itself arose out of the 1966 consolidation of the Boston Lying-In Hospital and the Free Hospital for Women. The change to the current and (perhaps) final appellation was, according to Brigham and Women's president Robert G. Petersdorf, "based on a desire to reflect a degree of continuity, a link with the past. These institutions have a 280 year history of medical and scientific achievements as well as an impressive record of unexcelled patient care. The new name symbolizes that tradition." Now that we've made everything perfectly clear. . . .

Folkman steps down as chief of surgery at CHMC

When he announced his decision to end his tenure as surgeon in chief at the Children's Hospital Medical Center, Judah Folkman '57 spoke of "the heavy administrative burden and inordinate demands of the position." He said he would step down September 15, "in order to devote myself more fully to other productive areas. Twelve years as surgeon in chief is a significant administrative contribution, and I believe the department of surgery will best be served at this time by different ideas and approaches."

Judah Folkman's own ideas and approaches have led the department to considerable success. Sixteen chief residents have trained under his direction and of those, seven are now chiefs of pediatric surgery or a related specialty, and all sixteen hold academic positions in major medical centers. During the same period more than six hundred published articles have originated in the department; approximately one sixth of that number were written by Folkman himself. Medical students have benefited from his guidance as the Julia Dyckman Andrus Professor of Pediatric Surgery, and in 1975 they chose him as their outstanding clinical teacher. And this year, for the third time, he was selected by the graduating class to speak at Class Day.

Led by Folkman, the CHMC department of surgery has pioneered programs in hyperalimentation, including adaptations for children undergoing chemotherapy for cancer; cranio-facial reconstruction for disfigured children; urology; the surgical treatment of solid tumors; kidney transplantation for children; and kidney dialysis for children (the dialysis center at Children's was one of the first of its kind in the United States).

One of the "other productive areas" for which Folkman now hopes to find more time is biological research. His current projects include: studies of the mechanism of tumor angiogenesis and its inhibition; the sustained release of pharmacological agents from implanted polymers; using the relationship between cell growth and cell shape — which he had demonstrated previously — to further the understanding of the differences between normal and malignant cells; and completing work on a new therapy for glycogen storage disease.

Academic moves

Merging with the already merged, the department of medicine at the Beth Israel Hospital has joined with its nascent counterpart at the Brigham and Women's Hospital to create a single academic department. Dr. Eugene Braunwald has agreed to chair the new body, thus adding to his already heavy titular load. Previously the Hersey Professor of the Theory and Practice of Physic and physician in chief of the Peter Bent Brigham division of the Brigham and Women's, Braunwald now assumes the Herrman Ludwig Blumgart professorship in medicine as well, a position formerly held by the physician in chief of the Beth Israel.

The agreement between the Medical School and the two teaching hospitals was announced on April 28 by Dean Tosteson. In addition to the appointment of Braunwald, the pact provides for a number of division heads who will be accountable to him. "The purpose of the consolidation," according to Braunwald, "is to develop an academic organization of the highest quality that will equal more than the sum of its parts in terms of depth and breadth of scholarship and research."

The clinical medical services at the Beth Israel and the Brigham and Women's will not be affected by the consolidation. The status quo of patient care, physician participation, and patterns of referral at each institution will remain intact. As spelled out in a letter of understanding, "a deliberate effort will be made to maintain the unique features and distinct flavors of the two hospitals."

Genetics chair endowed

In October of 1978 the HMS department of genetics was created by faculty fiat. Now, a year and a half later, as the result of a one million dollar gift from the Surdna Foundation, it boasts an endowed chair, the John Emory Andrus Professorship of Genetics. Soon perhaps Baruj Benacerraf's ad hoc committee on genetics, which has already drawn up a proposed structure for the preclinical department — the first new one in the Quadrangle in nearly two decades — may find someone to sit in that chair, as well as the other senior faculty members sought for the department.

The department of genetics will be responsible for teaching programs for

medical students, doctoral candidates in the Division of Medical Sciences, and postdoctoral scholars; for undertaking molecular and cellular research into basic genetic mechanisms and their relationship to development and inherited human diseases; for coordinating activities in genetics throughout the Medical School and its affiliated institutions; and for encouraging cooperative ventures among geneticists working elsewhere in the university.

The department is expected to continue and expand the research and teaching which until now have been carried out by members of the Center for Human Genetics. Some of the diverse facets of the discipline that will be studied are cytogenetics, somatic-cell, biochemical, and experimental genetics, prenatal diagnosis, the epidemiology of congenital morphological defects, amino acid and sex chromosome disorders, pharmacogenetics, and developmental, Mendelian, and population genetics.

A call to memories

In preparation for the Bicentennial of the Harvard Medical School (1982-1983), visual materials are needed — photographs, momentos, and the like. If you suspect that your attic or basement contains any hoary HMS treasures, please write Dr. Miles Shore at Massachusetts Mental Health Center, 74 Fenwood Road, Boston, Mass. 02115. *PLEASE DO NOT SEND ANY ARTIFACTS AT THIS TIME.*

A gift and a challenge

The Henry J. Kaiser Family Foundation helps those medical schools who help themselves. That, at least, is the gist of the message sent along with the $100,000 grants the foundation recently awarded to thirteen schools, including Harvard. An additional $50,000 will be given to the institutions that manage to raise another $100,000 on their own. If successful, they can claim the challenge money after January 1981.

Robert J. Glaser '43B, president of the Palo Alto-based foundation, explained their approach: "We hope the matching grant will provide the incentive for vigorous fundraising efforts, since the foundation's resources alone cannot make a significant impact on the indebtedness of students needing aid."

HMS belongs to a consortium formed eight years ago by the thirteen private medical schools which have been receiving scholarship money from the Kaiser Foundation. The group is comprised of the medical schools at Harvard, Case Western Reserve, the University of Chicago, Cornell, Duke, Johns Hopkins, Columbia, Penn, Stanford, the University of Pittsburgh, Washington University, the University of Rochester, and Yale. The schools share information relevant to their common situation, particularly with regard to the problems of providing adequate financial assistance to their students. It's probably safe to assume that these days they're pooling fundraising strategies — each hoping to add not just $100,000, but a cool quarter of a million to the coffers of its scholarship fund.

Attention for the chronically ill

The prognosis delivered by Dr. David E. Rogers, president of the Robert Wood Johnson Foundation, was to the point: "Unless regular, ongoing medical care is provided to control or arrest many chronic illnesses, they become insidiously worse, resulting in increasing discomfort, disability, or premature death." No one relishes such outcomes, but, as Rogers explained, in most office practices physicians lack the space, time, equipment, or special training required to give comprehensive, coordinated, and truly individualized care to patients who are chronically ill. In an effort to establish better long-term care for patients suffering from illnesses such as diabetes, hypertension, stroke, and arthritis — chronic diseases of the kind that account for half of the visits to doctors' offices annually — the foundation has awarded 4.4 million dollars to eight U.S. hospitals.

The Mount Auburn Hospital in Cambridge is one of those selected. (The Lemeuel Shattuck Hospital in Jamaica Plain has also received funding.) At the Mount Auburn, the money from the Johnson Foundation will support a new life resource center for patients with any of five specific chronic diseases: arthritis, cardiovascular disease, diabetes, Parkinson's disease, and stroke. The selection of these diseases was influenced by national and local prevalence rates, admission rates at Mount Auburn, the demonstrated need for multidisciplinary care of patients afflicted by them, and by current availability of programs that will support the complete care approach of the center.

"The life resource center will look at the patient's total life picture," said Bruce Ditzion, medical director of the center and instructor in medicine at HMS. "This means that in addition to coordinating patients' medical care, we'll help identify and find solutions to problems at work, in daily living, and with other family members when they relate to the illness. Such an approach aims to avoid hospitalization or institutional care, helping the patient live comfortably in his preferred environment."

Specially trained nurse practitioners will monitor each patient's illness and provide or arrange for the services prescribed by the person's physician. Medical specialists in the targeted diseases will also be involved, giving supervision and education to the nurses. Regular status reports will be made to each patient's physician.

Physical therapy, diet management, patient and family education and counseling all will be coordinated through the center and delivered in the setting considered most suitable for the individual patient. The possible settings include the ambulatory care center of the hospital, as well as neighborhood clinics, private physician's offices, and the patient's own home. The Visiting Nurses Association, Home Care Corporation, Residential Housing, and Family Service are among the agencies that will also be integrated into the life center's network of services.

Two hospitals gain on heart disease

After supporting five years of productive ischemic heart disease research at the Massachusetts General Hospital, the National Heart, Lung, and Blood Institute (NHLBI) has allocated more than $2,300,000 for the first year of a Specialized Center of Research on Ischemic Heart Disease (SCOR) to be based jointly at the MGH and the Brigham and Women's Hospital. Additional funding will be provided over the course of the next five years for both research and clinical studies. Edgar Haber, professor of medicine and chief of the cardiac unit at the MGH, is the principal investigator for the center; he welcomes the addition of what he termed "the complementary strengths of colleagues at the Brigham." One of those colleagues, Eugene Braunwald, Hersey Professor and chairman of the Brigham and Women's Beth Israel consolidated department of medicine, will be co-principal investigator, along with W. Gerald Austen '55, Edward Churchill Professor and chief of medicine at the MGH.

During the initial half decade of SCOR at the MGH, participants demonstrated the clinical applicability of a number of research findings. "Senior clinicians," Haber said, "working with the most advanced pharmacological and technological supports, had shown the possibility, through catheterization, of studying and helping the very acutely ill myocardial infarction patients on whom it had previously been thought too dangerous to work."

Some of the innovations pioneered at the MGH during this period are: a balloon pump to sustain heart attack victims until catheterization can define the defects; the successful use of the clot-dissolving enzyme streptokinase injected directly into the clot; diagnostic assessment through Thalium 201 imaging which differentiates between heart muscle cells where the damage is reversible, and cells which have been permanently damaged by heart disease; and the first use of antibodies as an imaging agent for diagnostic purposes.

Million dollars given for cost containment

Complete with initials that recall the innovative programs of an earlier decade of economic uncertainty, the soon-to-be-established Center for Cost-Effective Care (CCC) at the Brigham and Women's Hospital will search out ways to contain the costs of the modern teaching hospital. Financed by a three-year, $956,000 grant from the Commonwealth Fund, the CCC is intended, according to Fund president Carleton Chapman '41, "to evaluate merger economies and to oversee the integration into the daily clinical care of the hospital, new practical methods that decrease costs while maintaining the highest quality care."

A portion of the money will also be used to develop and expand the computer information systems at the Brigham and Women's, so that the CCC can summarize, store, and retrieve information necessary for an analysis of the cost-effectiveness of particular procedures.

W. Vickery Stoughton, vice president of the hospital, will direct the CCC and the studies related to its operation until a full-time physician director can be chosen. He is especially concerned with the physician's role in cost containment, both as the person who generates the largest proportion of hospital expenditures, and, consequently, the one whose attitudes and decisions will be most influential in the efforts to control those outlays. Stoughton has emphasized that although there are precedents for the analysis of the effectiveness of specific strategies of containment — for example, the Brigham and Women's has done research on test-ordering behavior and methods of clinical decision making — cost-conscious measures have not generally been incorporated into the daily care of the sick, nor into the institutional policies and clinical procedures of teaching hospitals. Strategies that will improve cost-effectiveness must be identified and implemented, whether they be clinical, economic, social, or administrative.

by Stephen Hoffman '81

a view from the bottom

Theater of the Rounds

I remember being puzzled, even in those prehistoric, preclinical days. How was I supposed to choose electives when I hadn't yet decided upon a career? In some consternation, I consulted a resident friend of mine. "Trust to time; it will all work out," she reassured me. "Take each experience as it comes and enjoy it for what it is. What to do will become clear." Although I was still itching with uncertainty, her prescription went far towards easing my discomfort. I trekked confidently through clinic and ward, living in quiet anticipation of the revelation to come. Now, a year later, I'm still waiting. What's worse, when certain of my classmates seem to have all but decided on the color schemes of their future homes, I find myself even more undecided than when I began my clinical peregrinations.

Still, until about a month ago, I was able to ignore my predicament. Then I met Sarah. I was doing my pediatrics rotation, and the seven-year-old had been brought to the emergency room because her mother had observed her tugging persistently at one of her ears. She didn't seem keen on having me insert the otoscope, so I tried to make friends. I asked her about school. "It's fun!" she told me. "And what do you think you'd like to be when you grow up?" "A neuropsychiatrist," said Sarah, neither of whose parents, I learned, had anything to do with medicine. "What about you?"

I have been preoccupied with career choices ever since. Sometime earlier, before Sarah's question, I had heard people begin to ask each other in earnest what they planned to do. The answers ranged from total undecidedness to utter certainty. One friend not only confessed his intention to specialize in neurosurgery, but also expatiated about the individual interests of department members at distant programs. Some students, like him, had arrived at their decisions on the basis of ward experiences, while others had known what they were going to do long before they came to med school. Some are now committed to fields they'd disparaged only a year or so before. One acquaintance has switched allegiance from surgery to family practice; another has abandoned psychiatry for rheumatology. A classmate told me she intends to take a year off, combining travel with off-the-beaten-track clinical experiences. "I need to exorcise a little bit of the romantic demon before I can settle down," she said. As another wardmate observed, "This is really the first time we've had to pin ourselves down to a choice. Becoming a doctor doesn't count; it's so easy and, in a way, noncommittal. So far our lives have been guided by simply striving for the best at every new stage. But you can pass yourself off as a student for only so long. Now it's time to declare your hand."

Asked at last to declare, people find themselves having to come to terms with motley aspirations and expectations, a sense of social responsibility, a moral imperative. A friend put it this way. "Part of me says it really doesn't matter which way I go — where I'm happy is as much a function of my personality as the field itself, and human beings have a remarkable ability to adapt to whatever situation they find themselves in. But a deeper part believes I've got to choose responsibly — both for myself and for others."

In principle, our clerkships are supposed to give us solid grounds for decision; in reality, we are rarely in one place long enough to feel that we can make an informed and confident commitment. Seldom do we find that single, inspiring physician, the elusive role model. We've wandered far and wide on the wards now for more than a year, like mendicants, collecting alms of information from the various visits, house officers, and other benefactors who happen by. Professors and house staff rarely come to know you past the point that enables them to supervise your work and write that little evaluation at the end of the rotation, a benedictory blessing and the surviving emblem of the experience. Passing in the hall a month or two later, you're lucky to receive a nod, let alone a hello.

Beginnings and leavetakings repeat themselves with uncanny regularity. First week. The excitement of being someplace new, that well-rested and bright-eyed feeling. Second week. Finally getting settled. Any romantic illusions rapidly fading. Third week. Eminently routine, getting bored. Fourth week. When is this ever going to end — why don't I run over to the Coop and pick up the things for next month? Then comes the purgative weekend ritual of cleaning up your room, emptying garbage, catching up on lost sleep and friends, all the while anticipating the role to come.

I have often felt like a performer in a repertory troupe, trying on the garbs of pediatrician, dermatologist, otolaryngologist. Getting psyched up for the next part, in quest of that sense of identity that you acquire in the instant you become the role you're playing. Living for that rare, heady rapport with your resident that may evolve late one night — when you've stayed up to talk about science, life, and caring. The next day you're dead on your feet, but you carry around something ineffable from the night before. Yet the intimacy is as evanescent as the way of the stage. The lights go down, the props are whisked away, you know it's all over. Reality becomes memory, fading slowly to nostalgic haze. It's time to learn a new set of lines; curtain time is never far away. You've washed your white coat (remarking that it seems to carry more marks than you do) and wonder for the thirteenth time where on earth you are going. An itinerant actor on the wards, you become known to almost everyone else, but remain something of a stranger to yourself. And you're still left wondering which specialty to choose.

"At present, some 225 HMOs provide health care for more than eight million Americans; the Kaiser program accounts for about fifty percent of this total."

In the last decade, health maintenance organizations, popularly known as HMOs, have become a focal point for those concerned with health care services in this country. The term HMO does not describe an exact generic type, but rather covers several different organizational forms, all of which have one thing in common: the basic costs of medical care — ambulatory as well as inpatient — for an individual or family are prepaid, usually by the employer. The comprehensiveness of the coverage varies so that in some prepaid plans relatively small charges are added for drugs, house calls, and often for long-term psychiatric care.

The prototype, in terms of size, reputation, and longevity, is the Kaiser-Permanente Medical Care Plan. The antecedent of the Kaiser Plan was originally established by Dr. Sidney Garfield, with the strong backing of the late Henry J. Kaiser and his son Edgar F. Kaiser, for workers employed in the construction of the Grand Coulee Dam in 1938. It was replicated during World War II for the two hundred thousand employees of the Kaiser shipyards, and ultimately went "public" after the war. Notwithstanding a shaky start, marked by vigorous opposition from organized medicine, the plan grew steadily and now provides prepaid, comprehensive care to more than three and a half million people in northern and southern California, Oregon, Hawaii, Cleveland, Denver, and Dallas.

The program has three components: Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and the Permanente Medical Groups. Kaiser Foundation Hospitals, a tax-exempt public charity, owns the plan's hospitals and ambulatory care facilities. Kaiser Foundation Health Plan contracts with the several Permanente Medical Groups, each an independent physician partnership, for the medical care services. The vast majority of members obtain their coverage through their employers — government agencies, corporations, unions, universities.

The Kaiser Plan represents but one form of prepaid group practice; there are several variations, with significant differences among them. In the so-called staff model the physicians are employed by the health maintenance organization itself. A prominent example is the Harvard Community Health Plan. Although most new HMOs begin as staff models, frequently the physicians tend to move toward a partnership agreement, and to work out a contractual arrangement comparable to that of the Kaiser physicians.

During the past ten years an increasing number of HMOs have been organized as independent practice associations, or IPAs. Some IPAs have been established under the sponsorship of medical societies, some by hospital staffs, and others by groups of physicians interested in combining various features of fee-for-service practice with prepayment. In an IPA, the participating physicians bill the IPA for care rendered, whether in the office or the hospital. Their patients prepay their care to the IPA. IPAs appeal to people who want the advantages of prepayment but at the same time wish to maintain an ongoing relationship with their physicians, assuming of course that the latter are associated with the HMO.

The development of an HMO is not a simple undertaking, and a successful operation — as exemplified by the Kaiser program, which now has annual revenues exceeding a billion dollars — is by no means assured. Indeed, a significant number of failures have been recorded. In the early phase, substantial financial support frequently must come by way of grants and loans from the federal government. The financial needs of an IPA or an HMO based on an existing group practice are less because the facilities for ambulatory care are already available, and the HMO thus avoids a major capital expenditure.

Encouraged by the federal gov-

Robert J. Glaser '43B is president and trustee of the Henry J. Kaiser Family Foundation and consulting professor of medicine at Stanford University. In a postscript, Dr. Glaser mentions that a grant from the Kaiser Family Foundation to the Association of American Medical Colleges will underwrite a two-day conference planned for mid-October in Colorado Springs that will explore the subject of medical school-HMO affiliations.

A Malleable Resource?

by Robert J. Glaser

Medical educators and prepaid health care advocates are trying to find out how much they have in common

ernment, as well as by large corporations and unions, the HMO movement is becoming a major force in American medicine. At present, some 225 HMOs provide health care for more than eight million Americans; the Kaiser program accounts for about fifty percent of this total. Other large endeavors include Group Health of Puget Sound (Seattle, Washington), Health Insurance Plan (New York City), Group Health Association (Washington, D.C.), and the Harvard Community Health Plan. It is acknowledged that HMOs provide care at a lower cost, primarily because of their lower rate of hospitalization. Given this fact, coupled with the current emphasis on the value of a competitive market, as championed by Alain Enthoven and others, the proliferation of HMOs will no doubt continue.

It is not surprising that academic health centers have become interested in the HMO movement. First, medical educators are concerned about maintaining adequate numbers of patients for teaching, and HMOs can potentially channel patients into a tertiary care system. Second, as more and more schools find themselves dependent on the income generated by their clinical faculty, they will likely consider establishing HMO types of practices to attract additional patients and the resulting increased income. Finally, HMOs can be valuable laboratories for certain types of health services research.

Kaufman and Heyssel describe the experiences of their respective institutions with HMOs. The situation at George Washington University differs in considerable detail from that at Johns Hopkins. At George Washington, the HMO is an integral part of the medical center, staffed by full-time academic personnel, whereas the two HMOs related to the Johns Hopkins medical institutions are not. The Columbia HMO, geographically distant, is staffed by physicians who hold clinical faculty appointments at Hopkins. The East Baltimore HMO presents special problems in that it serves an economically disadvantaged population; operation on a sound financial basis is dependent on a cost subsidy. In contrast, the membership in most successful HMOs tends to be made up of relatively young people who are generally healthier and less prone to chronic disease; their visits to physicians for serious problems are few and far between. They are therefore a distinctly different constituency than that seen regularly in most urban teaching hospitals.

Teaching of students in the ambulatory setting is time consuming and thus expensive — both in terms of space and the instructor's time. In contrast, successful HMOs are predicated on a high level of staff productivity, so that a large number of patients are seen, and space and the physician's time are utilized efficiently. In most HMOs, there is little or no teaching of medical students. It is all the more impressive then that the George Washington University Health Plan has incorporated teaching objectives into its modus operandi. In respect to residents, the consensus is that only in their third year can they function in an HMO on a cost-effective basis.

Of course teaching in the hospital is more easily accommodated than in the clinic. The patients occupy their beds twenty-four hours a day and teaching usually goes on as part of routine ward rounds without adding significant costs to hospital rates. Nonetheless, most HMOs use nonteaching (secondary) hospitals because of their relatively lower costs, and they usually refer patients requiring complex procedures, such as open heart surgery, to a tertiary center on a contract basis.

It follows that if medical schools wish to explore the HMO as a site for student and resident activity, especially in an ambulatory mode, attention will of necessity have to be directed toward the issue of educational costs. In all probability HMO members will not accept higher fees to cover the expense of teaching. An obvious argument in favor of involving HMOs in medical education is that students and house officers would gain experience in the care of patients more representative of society as a whole. Given that HMOs are not only here to stay but are certain to increase in number, it is appropriate for medical schools to consider arrangements that would be mutually advantageous to both the schools and the HMOs. As in affiliations with teaching hospitals, mutual advantages are a sine qua non for a successful relationship. □

CALLING THE ROLE FOR THE HMO

At George Washington, teaching is present and accountable

by Ronald P. Kaufman

In an article entitled, "How Do Health Maintenance Organizations Achieve Their Savings?" (*NEJM*, June 15, 1978), Harold S. Luft outlined some commonly accepted facts about HMOs: that total medical care costs are lower for members than for similar patient populations with conventional health insurance; that the rate of ambulatory visits is higher; and that the true key to lower costs is less hospital utilization — as represented by a reduced number of admissions — for both surgical and nonsurgical categories. (The concerns that have been raised about the quality of care — whether HMOs undertreat or outside physicians overtreat — have not been allayed one way or the other.)

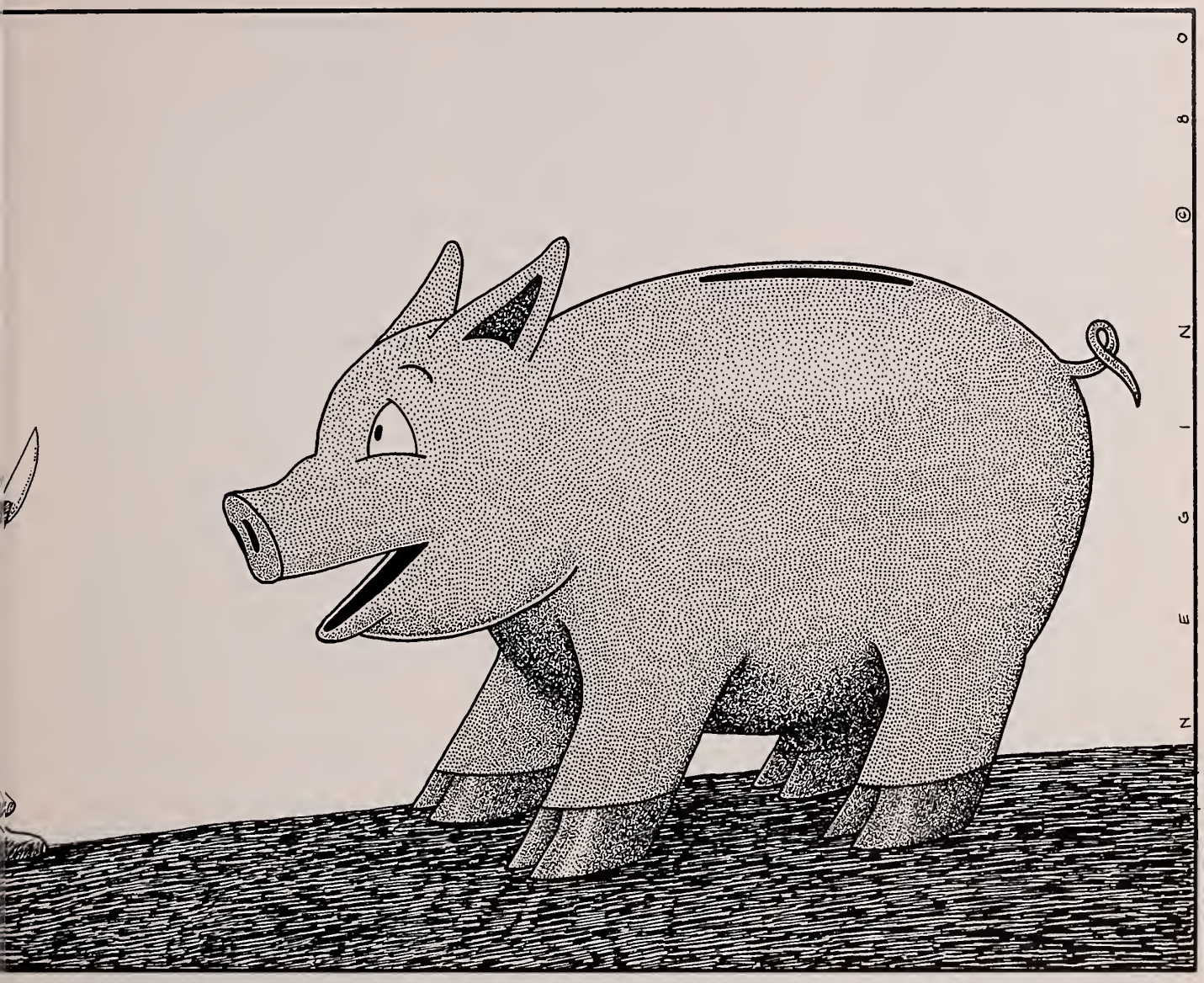
Despite the evidence that prepaid medical care can effect substantial cost savings, the HMO concept has failed to sweep the nation. This fact has been viewed, no doubt, with some sense of relief by a significant portion of the medical profession. Yet not even all proponents expect the HMO model to become the predominant form of practice in this country. What they do expect is that HMOs — which have been experiencing progressive growth and acceptance — will inject a measure of competition needed to forestall additional regulatory edicts intended to curb the escalating costs of medical care. Indeed, the federal government has wholeheartedly endorsed the HMO concept as a meaningful alternative to the traditional method of health care delivery.

The experience of George Washington University illustrates what happens when a teaching institution joins forces with two HMOs of entirely different configurations. Some of the conventional wisdoms — which in the minds of HMO proponents are considered absolutes relative to HMOs — were reflected in policy decisions made at George Washington over a period of eighteen years: the critical mass for a financially self-sufficient prepaid group practice is thirty thousand members; the best provision of medical care is by a multispecialty group based on a partnership arrangement rather than by physicians receiving straight salaries; marketing success and competitive pricing require successful identification and capture of a well-defined, sizeable service population; involvement in medical education, especially at the undergraduate level, should be extremely limited and is cost ineffective; the inpatient setting ideally should be owned and operated by the HMO; and, conversely, the utilization of a teaching hospital is incompatible with the cost containment measures needed for fiscal viability.

"Since physicians order the x-rays, lab tests, pharmacy services, and nursing care — all of which translate into major costs — they must be made aware of cost containment."

The George Washington Medical Center, created in 1966, is comprised of the School of Medicine and Health Sciences, the University Hospital, and the Medical Faculty Associates. The medical center's administrative head — who reports to the president of the University — is the vice president for medical affairs and executive dean. The Medical Faculty Associates is the designation for all full-time faculty (M.D.'s) who teach, do research,

(continued on page 11)



But in Baltimore, despite the best laid educational schemes, school's out

by Robert M. Heyssel

Competition, the free market, and deregulation are all very much talked about as solutions to the myriad problems of medical care. The almost knee jerk reaction of most physicians is that laissez-faire policies are just great — anything but more government intrusion in our profession. But do we understand what we are being asked to choose between? I am reminded of the story about the immigrant who was being examined by the judge in naturalization proceedings. Asked if he "advocated the overthrow of the government by force or violence," the immigrant looked puzzled for a few minutes and then replied, "by force, your honor."

Like the immigrant, I have been trying to determine if the answer to the question of competition versus regulation is yes, no, maybe, or a little bit of each. True competition and adherence to the economics of the marketplace — as reflected in the stance of the Federal Trade Commission — does not necessarily represent the right way to alleviate the complaints lodged against the medical establishment. Moreover, the impact of a competitive environment on medical education is a major concern.

The HMO movement has been one compromise in the direction of competition. In the greater Baltimore area, two HMOs have exerted a strong influence on the contours of medical care: the Columbia Medical Plan and the East Baltimore Medical Plan. Both organizations were started in the 1960s to demonstrate how prepaid group practices could work, with the intent that they also would teach primary care to Johns Hopkins medical students and residents. It is instructive to look at what has happened to these two plans.

The Columbia Medical Plan tee-

tered precariously on the brink of financial collapse for several years after building a hospital it could not afford. No longer the owner of a hospital, the plan is now breaking even based on twenty-five thousand members. Over thirty percent of the ambulatory visits are handled by nurse practitioners and others rather than by physicians. Although there is no explicit contractual relatonship between the two institutions, many of the Columbia physicians are faculty members at the Johns Hopkins Medical School.

While the plan is a success in numerous respects, the aims in regard to teaching and training have fallen by the wayside and will likely stay there indefinitely. The reason? Simply the economics of prepaid ambulatory group practice — there just is no money to defray the real cost of teaching. But Johns Hopkins and the Columbia Medical Plan have made a go of it in other ways: many of Columbia's physicians participate in teaching rounds at the Johns Hopkins Hospital and the plan has continued to be fertile ground for the Health Services Research Center at Hopkins.

The East Baltimore Medical Plan has had a more checkered existence, due primarily to its location in a poor area of the city, which has impeded its growth. Now in attractive new facilities, the plan — with fourteen thousand people currently enrolled — will be able to care for some twenty-five to thirty thousand patients, and is trying to qualify as a federally-approved HMO. But because all of its patients are admitted to the Johns Hopkins Hospital, the first question the feds have asked is, "Why don't you go to someplace cheaper?" Undoubtedly that will occur. Those people who can afford to pay or are covered by some form of third party payment tend to enroll in the plan, leaving the non-payers to seek care from the outpatient department at Johns Hopkins. These two trends are likely to continue.

In the long run, competition in the marketplace, at least as envisioned by some, may not be in the best interest of the patient. We tend to forget that if the fee-for-service system supposedly makes money by doing too much, it is also true that an HMO can make money by doing too little. I am uncertain that economic considerations alone can guarantee the quality of the care offered in an HMO. The economists and the FTC maintain that the Flexner reforms in medical education were really a plot to hold down the number of physicians, to foster specialization, and indeed to remove medicine from public scrutiny. Those in favor of competition must look beyond the possibility of immediate monetary gain or we will all be in trouble.

If the bottom line for prepaid group practice is price, and competition is the watchword, then how does the teaching hospital — which is almost always more expensive — maintain the resources for what it does best, sophisticated tertiary care? The extraordinary costs associated with tertiary care have been borne in part by higher charges for routine procedures. An appendectomy performed in a teaching hospital will obviously cost more than one done in a community hospital. So if price is the issue, then quite clearly HMOs are not going to choose teaching hospitals for inpatient care.

In the interests of their own survival, HMOs cannot do more than nominally wave the banner for medical education. In a system that is competitive, a different kind of funding mechanism will have to be devised for education; I have little confidence that such a dramatic change will come about. Already the impact of regionalization on expensive treatment modalities has pushed teaching hospitals towards becoming large intensive care units. As a consequence, academic medical centers will be less and less suited for the general teaching of medical students and internal medicine and pediatric house officers.

Despite the above critique, I very much favor the development of HMOs. I also favor putting more competition into the system. I applaud the rise of multi-hospital networks geared not just toward fiscal soundness but toward changing patterns of medical practice. Yet I am also partisan to the stake that the teaching hospital has in the delivery of health care and unwilling to let it become an expensive anachronism.

We who are the backbone of academic medicine ought to decide what our goals are. We need to decide where we are unique and what share of the marketplace rightfully should be ours. It is not an absolute given that every major teaching hospital has to engage in every kind of tertiary care; and for educational reasons, if no others, protean efforts should be reasonably discouraged. Physicians themselves must be involved in such decisions and in making them work. I firmly believe that one of the illnesses of the medical care system has been the division of authority and responsibility whereby the physicians spend the money but bear no responsibility for the consequences of their actions. We simply can no longer afford to invest in high-priced technological equipment that is inefficiently used. And we can no longer afford intensive care units staffed for one hundred percent occupancy that run at sixty percent. Since physicians order the x-rays, lab tests, pharmacy services, and nursing care — all of which translate into major costs — they must be made aware of cost containment.

We must be prepared to alter tra-

Mitchell Spellman, Dean for Medical Services and executive vice president of the Harvard Medical Center, is interested in the place of health maintenance organizations in the world of academic medicine. An appropriate theme came to mind for the meeting last November of the trustees of the Harvard Medical Center: the impact of changing patterns of medical practice on the teaching hospital. Drs. Ronald P. Kaufman and Robert M. Heyssel, whom Dean Spellman invited to speak on that occasion, are medical educators who have firsthand knowledge of the dilemmas — and the solutions — that arise when an HMO and a teaching hospital start courting one another in search of what Robert Glaser calls "mutual advantages."

Robert Heyssel is executive vice president and director of the Johns Hopkins Hospital and professor of medicine at Johns Hopkins School of Medicine. From 1969 to 1974 he was president, Columbia Hospital and Clinics Foundation. Ronald Kaufman is vice president for medical affairs and executive dean of George Washington University School of Medicine and Health Sciences, where he is also professor of medicine. He serves as president of the board of directors of the George Washington University Health Plan. These articles are abridged versions of their speeches.

ditional associations within the institution in response to both changing generic medical concepts and regionalization of services. Departmental lines are blurring. It makes more sense for neurosurgery and neurology — and perhaps psychiatry — to be partners in patient care, research, and education, than to have a department of neurosurgery under the domain of a general department of surgery. The same is conceivably true of other disciplines such as urology and nephrology. Furthermore, referral patterns to our institutions must be broadened so that we can act in conjunction with outlying hospitals.

We need to make reimbursement mechanisms more rational. In a competitive system, cost reimbursement and per diem rates are probably more inimical to academic medical centers than any other single factor. Under prospective rate reimbursement, our charges could relate much more to actual costs. While we might be marginally more expensive for straightforward medical care, many people, nevertheless, will choose us for the quality of our services.

As for competition with an HMO, it is my opinion that if we can't beat them, we should own them. What you own cannot take its business someplace else. An institutionally-owned HMO will incur higher hospitalization costs, but we are in a position to make a pitch for quality that will appeal to some people. At the same time we ought to seize the opportunity to think about alternatives to HMOs. Neither now nor in the future will a prepaid group practice plan be to everyone's liking. Many people will be satisfied with fee-for-service practice. Even within our institutions steps are being taken towards developing truly efficient group practices that can effectively compete for the fee-for-service patients.

A totally competitive and free marketplace makes me fear for our institutions, medical education, and quality of care. Yet if the changes that I have outlined take place I believe American medicine will be better off. What I clearly see for our future is regulation that fosters competition. □

GEORGE WASHINGTON

(continued from page 8)

and practice on a fee-for-service basis. The faculty practice plan was established in 1968 and is not a separate corporate entity, but rather a loose administrative organization within the medical center housed in a medical office building in geographic proximity to University Hospital, where ambulatory care is consolidated and integrated with the teaching program.

The George Washington University Hospital is a thirty year old, nonprofit, 530-bed unit that offers the usual array of services, with the exception of pediatrics, which is tied into the Children's Hospital National Medical Center. Out of an annual budget of fifty million dollars, University Hospital incurs educational costs of six million for the support of more than 350 house officers and the partial support of a large number of full service faculty. For the past seven years the hospital has enjoyed a balanced budget based on approximately 155,000 patient days or eighty-four percent occupancy. The per diem Medicare routine costs have risen from approximately $76 in 1974 to $126 on June 30, 1978. According to the annual Yale-New Haven Hospital survey, this per diem rate ranks George Washington at the bottom of a group clustered by federal per capita income SMSA group number 1.

From 1962 until 1976 George Washington University was affiliated with an HMO called the Group Health Association (GHA). Founded forty years ago, GHA now has an enrollment of 110,000 and operates five ambulatory centers — the largest of which is across the street from University Hospital. During the period of our relationship, physicians hired by GHA were awarded clinical faculty appointments at the medical school and appropriate admitting privileges at University Hospital. These physicians then elected to admit almost exclusively to University Hospital. In addition, through a separate agreement, the department of surgery — on a per capita basis — provided all surgical services needed by GHA patients.

The fourteen year relationship required a series of accommodations and diplomacy on both sides. And while not always smooth, it appeared to be mutually beneficial. The explicit understanding was that each potential GHA physician would be interviewed and prospectively screened by the appropriate departmental chairman. Although this courtesy was considered the rule, there were some occasions when it was neglected and the issues of academic appointment and admitting privileges precipitated a crisis. Yet overall the GHA saw University Hospital as a convenient, high quality inpatient facility that was a positive factor both in recruiting physicians and in marketing its health plan to the public. University Hospital viewed GHA as an important volume client, which contributed a spectrum of patients to the mission of medical education.

By 1976, inflation and rapidly escalating hospital costs caused GHA to review its position relative to the George Washington University Hospital. In February, GHA informed us that the surgical contract would be terminated — with the penalties paid for so doing — and the vast majority of their patients would be admitted to Doctor's Hospital, an investor-owned, for profit 284-bed facility. GHA physicians were still authorized to admit obstetrical and tertiary care cases to University Hospital. GHA predicted that this move would save over one million dollars a year; conversely, University Hospital estimated that the GHA patient days constituted approximately twenty-nine percent of its total revenues and eighteen percent of its admissions.

The George Washington faculty was enraged at this unexpected announcement. But their rancor abated quickly as the administration had its hands full trying to mitigate the impact of such a precipitous decision on the fiscal viability of University Hospital. During the next twenty months there were marked shifts in the patient census and a general fall in the level of occupancy. However, by November 1977 GHA usage of University Hospital had stabilized and remained essentially status quo until the summer of 1979, when Doctor's Hospital summarily declared bankruptcy and closed its doors within a ten-day period. This development has led the George Washington University Medical Center and the Group Health Association to review the possibilities for establishing a new accord. The proposal that

"Perhaps the largest issue to be considered by both the HMO and the teaching hospital is the uncertainty that surrounds the growth potential of the prepaid health plan."

appears to hold the most promise is for George Washington University to construct a free-standing facility of approximately seventy-five beds — physically connected to University Hospital — for the delivery of secondary care to GHA patients. Contractual arrangements would be developed between GHA and University Hospital for the continuation of obstetrical and gynecological services, as well as with other clinical departments for the delivery of tertiary care. Although these discussions are still in the exploratory stage, both parties see the potential fiscal and educational benefits of such an arrangement.

George Washington University gave birth to its own "unique" HMO in 1972, which, understandably, has been immune from the sort of vicissitudes that beset the University and GHA. Its uniqueness comes from the fact that all the George Washington University Health Plan physicians are full-time faculty of the Medical Center in the department of health care sciences. The pattern of growth has been modest but continuous, with a current membership of some 20,500, of whom approximately sixty percent are federal employees. The one centralized ambulatory facility near the Medical Center will be augmented on or about July 1, 1981 by a second site in northern Virginia, which will be able to accommodate another eight to ten thousand members. All inpatient admissions are to either University Hospital or Children's Hospital National Medical Center.

The GW plan was begun without federal subsidy, grants, or loans and at present is fiscally solvent with $2.5 million in equity. Its organizational structure reflects a fairly intimate relationship with the university administration. The George Washington University Health Plan, Inc. is a separate corporation; however the majority of its directors — appointees of the president of the university — carry major administrative responsibilities either in the university or the medical center. The remaining positions are filled by business leaders, Blue Cross officials, and plan members themselves. Contractual agreements are set up with Blue Cross for hospitalization coverage as well as for excess reinsurance; with the department of health care sciences for primary care physicians, nurse practitioners, physicians' assistants, and administrative staff; and with the medical center for administrative support services. In addition, the plan contracts on a capitation basis with the academic departments represented in the faculty practice plan for specialty, consultative, and diagnostic services.

The George Washington University Medical Center encouraged and supported the development of this HMO primarily as an educational vehicle: via a controlled setting, students would have the opportunity to experience both ambulatory practice and the prepaid practice mode. Medical undergraduates are involved in the plan most intensively in their third year when they take a required eight week primary care clerkship there. In their fourth year, they can elect a follow-up rotation. Physician assistant and nurse practitioner students also use the plan as their major clinical site for instruction in primary care. The teaching costs for medical students — published in the *Journal of Medical Education* in July 1979 — show a total cost per student per day of $54.20.

At the graduate level, the program in primary care involves five second-year internal medicine residents and four third-year pediatric residents. Each spends five sessions weekly on one of the primary care teams in the George Washington University Health Plan. The results of a recent survey reveal that the residents add approximately $1.50 onto the base charge of $14 per visit. Our data clearly indicate that education in an ambulatory setting significantly increases the cost of health care services provided by an HMO. Nevertheless, the program has been extremely successful and is viewed by the majority of students as a constructive experience. The primary care residency program, which is predominantly office-based, with an admixture of pediatrics and internal medicine, is quite popular and in our view offers a reasonable alternative to the traditional family practice model for primary care in an urban setting.

The other major motive behind the establishment of a prepaid medical plan at George Washington was to create a laboratory for research in medical care and delivery systems. The health system evaluation programs, presentations, and publications that have emerged from the GW plan have more than justified its academic worthiness. An annual budget of $250,000 from the medical school supports faculty and staff of the department of health care sciences. And a variety of sponsored research programs are currently funded at $725,000. These funds compensate some sixteen full-time faculty — twelve physicians and four allied health professionals — at a level of nearly twenty percent of their efforts, or three-plus full-time equivalent faculty of the department of health care sciences. In addition to their base pay from the University, the physician faculty members participate in an incentive income faculty practice plan, which, during fiscal 1979, generated average bonuses of seven thousand dollars.

HMO physicians have exactly the same admitting privileges to University Hospital as their GW faculty colleagues and they take a principal role in the management of their patients. In this way, they can control admissions, length of stay, and the diagnostic services performed. In fact, the

number of admissions, other than for obstetrics, is relatively small — slightly over four thousand patient days annually. The George Washington University Health Plan has remained competitive precisely through deliberate control of hospital utilization, as well as through the extensive use of nurse practitioners and physician assistants in ambulatory care. These conclusions are predicated on a comparison of inpatient utilization data: 733 days per thousand members per year for Blue Cross coverage; 408 days per thousand members per year for all HMOs; and 362 days per thousand members per year for the George Washington University Health Plan.

An interpretation of the admission statistics indicates that the rate for Blue Cross is approximately 118 per thousand members per year, whereas the figure for the George Washington University Plan is 71.7. The average length of stay does not seem to vary according to type of insurance coverage. In Washington, one has the advantage of being able to compare uniformly the costs to federal employees of the various plans; the family premiums for 1980 are as follows: Blue Cross/Blue Shield, $124.54; Group Health Association, $145.95; Georgetown University Health Plan, $135.11; George Washington University Health Plan, $128.62. Out of this group, the GW plan was the only one that did not increase its premium this year.

Our plan makes use of a full service faculty; it undertakes a significant responsibility in medical and allied health education; it maintains a modest but proven primary care residency program; it has a small membership of 20,500, served by one geographic center; and it admits patients to a teaching hospital. Despite some seeming contradictions to established tenets of HMO management, the GW Health Plan has a highly competitive premium structure and is fiscally solvent, with a substantial reserve.

Having reviewed two disparate experiences relative to prepaid health plans in the Washington area, I offer the following generalizations: 1) The rheostat on the attitude toward hospital utilization is a greater factor in cost control than the average per diem cost of a single hospital day. 2) Joint involvement of the hospital with the HMO in recruitment and selection of staff is an important prophylactic both to avert conflict and to create positive peer relationships. 3) Open discourse about the trade-offs inherent in the relationship is critical, with special emphasis not only on the marriage contract but also on the required settlements if separation and/or divorce occur.

I am not suggesting that the experiences of George Washington University with the Group Health Association — a mature and large HMO — and with the George Washington University Health Plan — a nascent, fiscally stable, federally qualified plan —can be directly translated or implemented in other teaching institutions. They may well have been specific as to time, place, and organization. Nor do I offer any easy answers to why a plan with built-in educational costs, through the involvement of a tertiary hospital, can be and is cost effective. When the HMO physicians can maintain collegial relations with other physicians within the hospital it is easier for them to control the length of stay, consultations, and orders written on their hospitalized patients. Moreover, the presence of senior house staff contributes greatly to patient care and enables the HMO to reduce the number of full-time primary care physicians and other health professionals it employs.

Admitting privileges, delineation of authority, bed access, and operating room priority can become divisive issues, since it is difficult for the hospital selectively to exclude individual physicians who are practicing together under the auspices of a recognized HMO. In my view, negotiated contracts are required and must specifically stipulate the search and selection process for those physicians who will be granted admitting privileges, and what procedures will be followed if disciplinary actions are taken by the teaching hospital against an HMO physician. The contract should also designate the manner in which beds and staff will be assigned.

Perhaps the largest issue to be considered by both the HMO and the teaching hospital is the uncertainty that surrounds the growth potential of the prepaid health plan. If the teaching hospital has a direct involvement in an HMO, it faces fiscal risk should the plan fail. However, even without direct involvement, serious problems can be caused either by rapid growth or by sudden decrements in membership and/or the utilization of the hospital. In view of "open season" requirements and the "dual option," it is unlikely that one or the other party can fully control these possible swings early in the life of the HMO. Depending on the number of options a prepaid plan offers in its choice of hospitals, it is obvious that the sudden withdrawal of a significant percentage of a teaching hospital's admissions can cause a major upheaval. As HMOs enlarge, they often develop their own specialty staff and services, which can strain the relationship with the fee-for-service hospital consultants. Accordingly, all relevant issues must be explicitly addressed and resolved prior to a final agreement.

Based on our experience, a prepaid medical plan can cohabit with the teaching hospital if the trade-offs are clearly understood, accepted, and strictly enunciated in a contract. In return for the opportunity to educate students and/or house staff in primary care, the hospital may wish to offer the HMO access and some selective priorities. The HMO, in accepting the probability of a high per diem, may appreciate the prestige that the teaching hospital gives to its recruitment and marketing efforts.

I have no doubt that the HMO movement, bolstered by federal support, will survive and become an increasingly potent force in more and more areas of the country. If the affiliation between the HMOs and the academic sector is unsuccessful, a separate hospital and teaching system will be required to sustain the HMO movement. Such a duplication cannot be condoned by planning agencies or by the academic community. If prepayment is to become a significant element in the health care system of this nation, then medical schools and teaching hospitals must continue their well-accepted responsibility to prepare medical and allied health personnel and, therefore, must prepare them with experiences in the prepaid setting. □

Harvard Community Health Plan

After several years of planning and negotiating, the Wellesley Center of the Harvard Community Health Plan opened on July 1, 1980. Some local alumni have been troubled by HCHP's apparent leap into the suburbs and have sought an explanation from the Medical School of the extent of a direct kinship between HMS and what is commonly known as the Harvard Plan. The issue was brought before the Alumni Council (prompted in part by the exchange below) and addressed by various involved parties and impartial observers. No conclusions or motions regarding HMS and the status of HCHP were recorded during these sessions. Nevertheless, the consensus was that the dialogue should be opened up to the alumni, and that we have done as completely as possible.

What's in a name?

Dear Dr. Christensen: **December 18, 1978**

Since my graduation from Harvard Medical School in 1959, I have contributed annually to the Harvard Medical School Alumni Fund without fail and this certainly has been one of my pleasures. It is with some sadness that I shall not contribute this year nor in the future or at least until that time when my medical school honestly and in forthright fashion discusses its role in the development and propagation of the Harvard Community Health Plan. As you must know, the Harvard Community Health Plan is a well organized and successful prepaid medical program functioning in the Greater Boston area with active intentions of spreading further into the suburbs in the very near future.

I firmly believe that prepaid medical programs of various types have the right to exist and to compete with the more traditional forms of health care in the marketplace. This type of competition is an important part of the American system. However, I am very distressed to find that my medical school has given its name (a rather important name to say the least) to one particular prepaid program which is now called the Harvard Community Health Plan. As best that I can understand, the Harvard Plan hires a variety of physicians not necessarily the graduates of Harvard Medical School and this plan is also anxious to affiliate with hospitals not necessarily affiliated with Harvard Medical School. Recently it has been announced that the Harvard Community Health Plan will be opening a large branch in Wellesley, Massachusetts only a few hundred yards from the Newton-Wellesley Hospital, which is a large community hospital affiliated with the Tufts University School of Medicine. I personally am not bothered nor are many of the other physicians in this area by having to compete with a prepaid program as discussed above, but it is distressing to have to compete with the name Harvard. Already a number of persons and patients in my community have quite frankly discussed with me the fact that it would be perhaps advantageous for them to switch their care from their local physicians and the Newton-Wellesley Hospital to the Harvard Community Health Plan because "we will be receiving Harvard care, which must be the best."

"I am sorry to see that my medical school has blatantly endorsed one system over her graduates who may be doing conventional health care in eastern Massachusetts."

I seriously question whether the Harvard Medical School has the moral right both to lend its name to a competing form of health care and at the same time solicit funds from graduates of the Harvard Medical School who are forced to compete with the Harvard name. Once again, I stress that it is important and probably good for the various types of medical care systems to compete in the marketplace but I am sorry to see that my medical school has blatantly endorsed one system over her graduates who may be doing conventional health care in eastern Massachusetts. Although I am saddened by my not being able to contribute to the alumni fund this year for the first time in twenty years since my graduation, I do hope that other graduates of Harvard Medical School who are practicing in Massachusetts adopt a similar position at least until the Harvard Medical School addresses itself to the above stated issues.

Sincerely,
James J. Sidd '59
Associate Professor of Medicine
Tufts University School of Medicine

Dear Dean Tosteson: **December 27, 1978**

It was most distressing to read the letter my classmate, James Sidd, wrote to Dr. Christensen on December 18. I know Dr. Sidd to be a sober, unconservative physician who would write such a letter only after much thought. I would appreciate your comments on his letter because the answers to the questions he raises have fundamental significance both for medicine and for government involvement at and with Harvard Medical School.

"Could it be that the Harvard Community Health Plan wants to expand from Boston to the suburbs because serving the poor is a losing financial cause?"

Harvard has always received large amounts of federal funding. In the fifties and early sixties this was done through grantsmanship for basic research. More recently, recognizing the push for patient care on the part of the federal government (and, I suspect, only for this reason), Harvard has become involved in HMOs.

That medical schools should be so involved in areas of geographical continuity seems to make sense: their emergency rooms function as local physicians in any case. But how service to local areas can be construed to mean Newton-Wellesley is difficult for me to comprehend. I would suspect that such a wealthy, suburban community already has an excess of physicians. Could it be that the Harvard Community Health Plan wants to expand from Boston to the suburbs because serving the poor and relatively poor is a losing financial cause? Are government subsidies about to be cut back and so even Harvard's HMO will succumb to economic realities? To be specific: would the Harvard Community Health Plan be currently running in the red if there were no government subsidies? And will branches in wealthy suburbs help balance the books?

I feel this whole matter deserves a complete and open discussion among all concerned with Harvard Medical School. Although for many years I have personally pushed for Harvard to become more involved with primary care, as a pediatrician practicing in a poor rural area of New York State, I have been rather cynical of Harvard Medical School's movement into HMO grantsmanship while still philosophically denigrating primary care. A move into the suburbs away from the patients who need physicians but can't afford them and to those who have both care and money in surplus, would confirm my cynicism as being appropriate.

Sincerely,
Ira Marks, M.D.
Class President, HMS 1959
Primary Practitioner of Pediatrics
Chatham, New York

Dear Dr. Marks: **January 30, 1979**

I regret the delay in responding to your thoughtful letter of December 27 commenting on the letter which your classmate, James Sidd, sent to Bill Christensen in his capacity as the President of the Harvard Medical Alumni Association.

The Harvard Community Health Plan is an independently incorporated, nonprofit institution involved in delivering primary care in Boston. Its financial operations are entirely separate from the financial operations of the Medical School. The decision of HCHP to establish a clinic in the Wellesley area is completely unrelated to the financing of the academic programs of the School.

I do not know all of the reasoning behind HCHP's decision to establish a unit in the suburbs. I do know that the corporation has not only balanced its budget but also managed to pay off a substantial fraction of the loans which financed its establishment. Although it has thus far been exclusively an urban program, it has by no means catered

preferentially to the poor. Its distinctive character has been that of a prepaid group practice involved in delivering primary care, a setting not present elsewhere in the Harvard community.

It is a serious and unanswered question as to whether the Plan should continue to be called the *Harvard* Community Health Plan. The establishment of the venture was stimulated by Dean Ebert and others at the Harvard Medical School. The University provided substantial front-end funding. However, at the present time, the involvement of the staff of the HCHP in the academic programs of the Harvard Medical School is substantially less than is the case with most of the hospitals with which we are affiliated. This lost opportunity distresses many members of the faculty, and the alumni. We will be discussing the issue during the coming months in the hope of finding a happier solution.

"The corporation has not only balanced its budget but also managed to pay off a substantial fraction of the loans which financed its establishment."

Please know that Harvard Medical School does not "philosophically denigrate" primary care. To the contrary, we have been busy strengthening our educational and research efforts in this field during the past years and particularly during the past eighteen months. I have asked Dean Spellman, our new Dean for Medical Services, to prepare for you a description of Harvard-related activities in primary care which may interest you.

Sincerely,
Daniel C. Tosteson, M.D.
Dean

Dear Dr. Marks: **February 12, 1979**

Dean Tosteson sent me a copy of your letter of December 27, 1978, together with a copy of his January 30th reply. I was distressed to learn that the Harvard Community Health Plan has become a subject of concern to your class. I am particularly sorry that Dr. Tosteson must bear the brunt of these criticisms since the blame is entirely mine. Had I not become Dean in 1965 there would be no Harvard Community Health Plan today and, therefore, no controversial issue — or at least not this one — to upset members of your class. I do not apologize for having fathered one of the most successful prepaid medical care plans in the country and the first to be developed in a university environment, but I would be naive if I failed to recognize that success offends more often than failure. Probably I will not change your convictions, nor those of your classmates who oppose the plan, but at the very least I can present some facts for your consideration.

"In the 1970s HCHP was used as a paradigm by HEW in the department's efforts to stimulate interest in prepaid group practice."

1. The Harvard Community Health Plan was conceived in 1965-66 before the name Health Maintenance Organization was invented or at least in common usage and before any federal funds were available for planning HMOs. You will also recall that this was a time when biomedical research funding was going up and not down and *before* any but a very few of us were worried about such things as primary care and how medical care might be organized. Our efforts at Harvard not only preceded the "push for patient care on the part of the federal government," but in the 1970s HCHP was used as a paradigm by HEW in the department's efforts to stimulate interest in prepaid group practice.

   I do not for a moment believe that the facts will in any way alter belief in the myth that Harvard became interested in prepaid medical care after there was a decline in federal funding for research and fostered HCHP only because federal grants for HMOs were available. Myths are always more comforting than reality and this one has been around for some time.

2. Let me elaborate on the statement made in Dean Tosteson's letter: "The University provided substantial front-end funding." I can vouch for university support since I personally raised the money from foundations to start HCHP and all of it, with the exception of one large grant, was raised for that specific purpose. That one foundation grant was given for a "Dean's discretionary fund," and although it could have been given as a grant to HCHP, instead it was used in the form of a loan which is being repaid to Harvard with interest. The important point is that only new money was used, only private money from foundations and, of course, no money given the Medical School by alumni was ever used.

3. HCHP was conceived and inaugurated by Harvard, and I suppose that is the reason it was given the name Harvard Community Health Plan. (In my view only Harvard was sufficiently unafraid to move into what for a university were uncharted waters and be successful.) As a matter of policy it was started as a separate corporation since we wished to have it organized in a manner that was compatible with other Harvard-related institutions. In addition, after start-up funding we wished to have the finances separated from those of the Medical School so that we would be able to judge its fiscal success or failure from its balance

sheet. As Dr. Tosteson has stated, the Plan is in the "black" and has an excellent credit rating with the banks. Your suggestion that the Plan is expanding to the suburbs because it is losing money in the city is totally unfounded as is your thesis that HCHP is sustained by government subsidy. The only government grant is for the partial support of a sample population in the Mission Hill area which is medically indigent and not eligible for Medicaid. If that grant were discontinued it would have no impact on the Plan's financial viability.

4. There were multiple reasons for starting HCHP. One was to provide a different kind of setting for teaching. But teaching was not the primary reason and in explaining why I shall reveal some of my convictions (or prejudices) about medical education. I believe the most propitious environment for the teaching of clinical medicine is one in which the interests of the patient come first. In my experience clinics designed first and foremost as "teaching clinics" frequently provide inferior care and, therefore, do not offer the best learning environment for fledgling physicians. I am even more skeptical than you are of reliance on federal grants for patient care and from the beginning it was assumed that HCHP would have to become financially viable and independent or would be compelled to fold. All of this meant that the first task was to build a prepaid medical care plan which provided high quality comprehensive care, was financially viable and once started could compete without subsidy from the university or government. Only then would there be the kind of stability which I believed was needed for the best teaching environment.

   That has been accomplished and the facts are that HCHP has been a central force in the development of primary care residency programs at Harvard. In my view residency training had to precede the use of HCHP for medical student teaching. I believe we must now experiment with how to use HCHP effectively for teaching of medical students and the problem isn't very different from the one you would face in your private office with your private patients. It should be noted that the issue is how best to use HCHP for medical student teaching and not the participation of HCHP physicians in teaching. All HCHP physicians with HMS appointments (and this is the majority) do participate in medical student teaching in the Harvard hospitals where they hold their clinical appointments.

"HCHP was conceived and inaugurated by Harvard, and I suppose that is the reason it was given the name Harvard Community Health Plan. Only Harvard was sufficiently unafraid to move into what for a university were uncharted waters and be successful."

A dean's lot is not a happy one. You and some of your classmates have objected to the use of Harvard in the name, Harvard Community Health Plan, and a dean is always sensitive to the feelings of alumni. But 38 of the 112 HCHP physicians are HMS graduates and 71 had some or all of their training in Harvard affiliated hospitals. They might be expected to espouse an opposite view to the one you hold and so, as with many other issues, the dean is in a no win game.

I have tried to outline in this letter some of the facts about HCHP, and I have tried to correct some of the misconceptions about the Plan hoping that this might modify your feelings about alumni giving to HMS. Now let me appeal to you on more personal grounds. I do not for a moment suggest the end of controversy or wish to deny you the right to object to (or approve of) anything that goes on at HMS. But do not mix up an expression of your convictions with support for your alma mater. In my view, Harvard Medical School is a unique medical school, deceptively simple in appearance and infinitely complex in its subtle interrelationships with other institutions. It is the premier medical school in the world today and probably the finest that has ever existed. It is with awe and somewhat uncustomary humility that I reflect on my twelve years as Dean. My point is that no matter what happens at HMS with which I might disagree, I would not wish to see the institution hurt, and I would wish to support the Medical School even though I might be critical of people and programs. I hope you will wish to do the same. If publicly or privately you take pride in your past identification with Harvard Medical School then you will only diminish yourself by refusing to give the institution your support simply because a controversial issue has not been resolved to your satisfaction.

Sincerely,
Robert H. Ebert, M.D.

Dear Dr. Ebert: **March 5, 1979**

Thank you very much for your informative letter of February 12. I think the facts mentioned in it regarding HCHP should be more widely publicized. Perhaps the recent alumni discussion about the plan will begin to set aside the myth of which you speak.

As for myself, I am pleased to learn that HCHP is a prepaid group practice that is succeeding financially. I came to Columbia County to join the Rip Van Winkle Clinic, with which I believe you are familiar. Consequently, I am sensitive to group practices

which survive financially only with outside monies. I believe The Rip Van Winkle group would have succeeded had it been more realistic on this issue. My complaint about HMOs is not that they are prepaid group practices but rather that they need government subsidies and, often, their apparent desire to immerse themselves in government bureaucracy (particularly their desire to increase their annual grant whatever the need) in preference to patient care.

When you stated, "Your suggestion that the Plan is expanding to the suburbs because it is losing money in the city is totally unfounded as is your thesis that HCHP is sustained by government subsidy," you completely demolished my myth about HCHP; I hope someone will similarly inform others in the Harvard community. Apparently I am not the only one so misinformed, this despite an active alumni organization and the *Alumni Bulletin* and the presumably good access Harvard has to the media.

However, I wonder if the use of the "Harvard" name in the Community Health Plan is appropriate. This is what my classmate, James Sidd, complained of. (The HMO and primary care issues were my prejudices, not his.) This issue is not as easily handled since it involves opinion and not fact. Personally, I sympathize with Jim even though I fully support your concept of incorporating resident training and, eventually, student training in private practice. Moreover, I would support such experience in all practice areas including group, group prepaid, private, partnership, incorporated, and even HMOs. Anything to present medicine as primarily an office, personally oriented "art," and not a hospital, lab oriented "science."

Your letter removed my misconceptions regarding the HCHP. Nevertheless, it did not relieve my anxieties about the bias of Harvard and its teaching hospitals against primary practice. The fact that Harvard, but more realistically, you, became interested in prepaid medical care before there was a decline of federal funding for research, does not alter this feeling. If Harvard was interested in primary practice, why were there no rotating residencies available (for example, similar to those at Rochester) at its teaching hospitals until federal involvement pushed in this direction and/or you came into the picture to push the idea of office practice as part of the full teaching curriculum? This is not to suggest that the MGH should become a local community hospital; I don't want Harvard to change radically. I only want to remind the powers that be that full-time physicians at medical schools and at high powered teaching hospitals simply cannot present the total picture of medicine to residents or students. (No more so than the AMA should represent "medicine" to the public or the Congress.)

As regards my support for the Medical School, it was Dr. Sidd, not I, who withheld his contribution. I do not agree with this position. I wrote Dean Tosteson in an effort to get the facts as he had not answered Dr. Sidd. My support for Harvard has never ceased but I still feel that the issue of the use of Harvard's name by any private organization is an appropriate one to raise. As class agent I feel responsible both to my class and to the School.

I agree Harvard is probably the premier medical school in the world. In my opinion it has achieved this stature in no small part because of the intelligence and the independence of its students. As a result, differences of opinion will always be strongly expressed and apparently endless, something you must know as well as anyone can. It is my firm belief that discussion and resolution of various problems leads to increased support in the long run, whatever the short term setbacks.

Thanks once again for taking the time to write your letter. Although it may not have changed many of my convictions, you did eliminate a myth. It was very much appreciated.

Sincerely,
Ira Marks, M.D.*

"My support for Harvard has never ceased but I still feel that the issue of the use of Harvard's name by any private organization is an appropriate one to raise."

* *Editor's note: Due to an unfortunate oversight, Dr. Marks was not informed until just before our press date that the* Bulletin *was publishing his letters to Drs. Tosteson and Ebert. Had he had advance notice, he would have asked to comment further, both about the initial funding of HCHP — which, although private, was quite large and was secured through HMS channels — and about the educational relationship of HCHP to HMS — particularly with regard to HCHP's purported role in primary care teaching. Dr. Marks will address these matters in a letter to the editor in a forthcoming issue.*

In the Alumni Council: January 25, 1980

JAY KAUFMAN '66

I was an ophthalmology resident at the Massachusetts Eye and Ear Infirmary, I teach Harvard Medical School students one month a year in their course in ophthalmology, and I spend a half day in clinic every week at the Mass. Eye and Ear. I have a very low academic rank at the Harvard Medical School (clinical assistant in ophthalmology, part time) and in general am a doctor who took one of the traditional paths, going into private practice with a strong affiliation at Harvard. Now despite all of this I can't call myself a Harvard Ophthalmology Associate, but opening in my community this summer there will be an insurance company that employs doctors — many of whom will not have been educated at Harvard Medical School, and many of their patients will not be admitted to our teaching hospitals — and they are calling themselves the Harvard Community Health Plan. I don't want to minimize the fact that they are calling themselves the *Harvard* Community Health Plan, insofar as that is the single strongest asset that this independent corporation has; if they were to call themselves the Greater Boston Community Health Plan they wouldn't have nearly such an impact in a community like Newton-Wellesley.

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JAMES SIDD '59

I graduated from the Harvard Medical School in 1959 and went through the training program of the Harvard Medical Services at Boston City Hospital. I have switched allegiances at several opportunities, but for the last several years I've been on the faculty of Tufts Medical School, where I've risen to associate professor. I spend the vast majority of my time in pure academic medicine as a cardiologist and on the faculty at Tufts, and have a really small practice in terms of my position at Newton-Wellesley Hospital. As an HMS alumnus, I have been interested to watch the growth of the Harvard Community Health Plan from its origin in Kenmore Square. My concern has grown, and along with a number of Medical School graduates who have worked at our hospital — very fine people, many of them highly academic individuals — I am deeply hurt; all of us are deeply concerned.

We all recognize that the Harvard Community Health Plan has a perfect right to exist — as does any HMO. I think they have a role to play; they may, in fact, win out in the marketplace. I could even see myself in a few years, when I have my last child in college, beginning to atrophy — I might well wish to work for the Harvard Community

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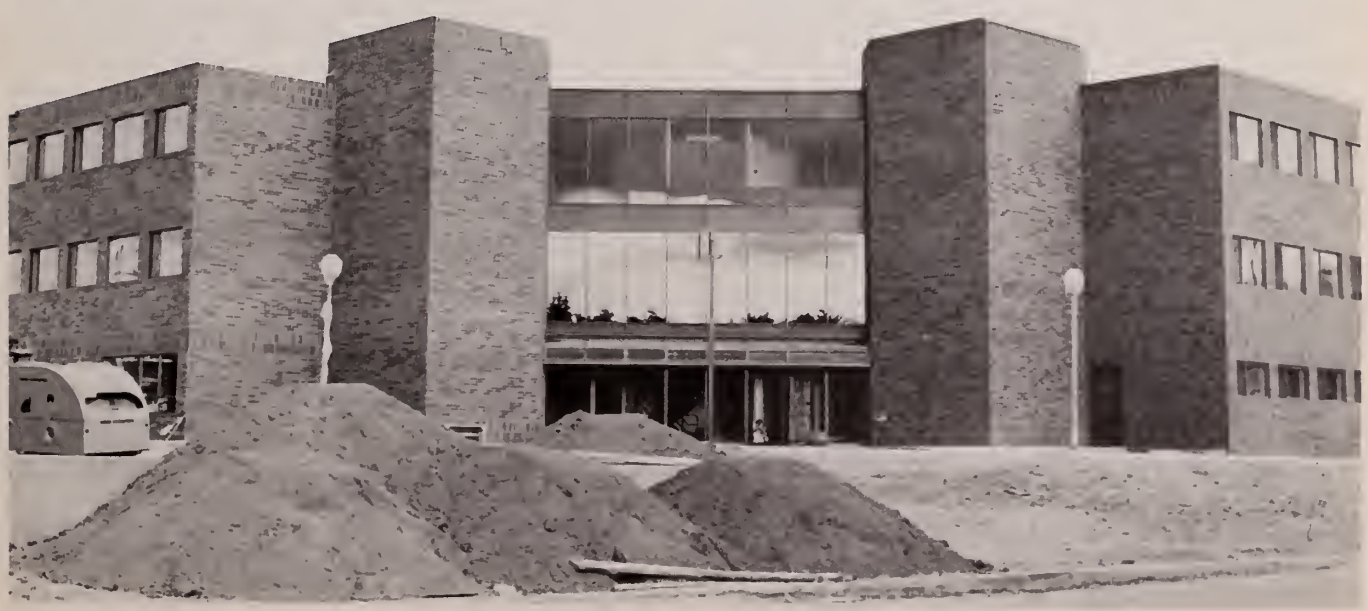
HCHP in the suburbs: the Wellesley Center started life on July 1, 1980 with six thousand members and a full-time complement of internists, pediatricians, obstetricians, and gynecologists. The center will be able to accommodate a projected enrollment of 40,000 people. HCHP currently cares for some twelve thousand west-of-Boston suburbanites and, according to one administrator, a higher proportion of families are expected to join the Wellesley Center than has been the case at its urban counterparts. James Sabin '64, a psychiatrist at HCHP since 1975, is the medical director.



In the Alumni Council: January 26, 1980/ June 3, 1980

GORDON MOORE '64 medical director, HCHP

I think that when Bob Ebert conceived the Harvard Plan he hoped that it would generate both pride at Harvard Medical School and opportunities for teaching, research, and patient service — the things on which this medical school is founded. And for an organization that has only a ten year history we really have accomplished a hell of a lot. We're serving eighty-three thousand members in the Greater Boston area and providing first class patient care.

We have had, from the outset, a major focus on participating in and in fact being a leader in some of the teaching activities at HMS. Eighty-six percent of our physicians have Harvard faculty appointments. In any one year about eight or nine out of ten are doing some teaching either of residents or medical students at Harvard Medical School. There is a tremendous commitment to teaching — carried out, in general, through our affiliated institutions. We do not now have faculty appointing power at the Medical School; consequently, we have our appointments through parent departments at the Peter Bent Brigham, the Beth Israel, the Boston Hospital for Women, Children's, and, in particular, Cambridge Hospital. We were the stimulus to start the primary care residency program at Harvard Medical School — Joe Dorsey had a major part in that — and we currently are the site for the ambulatory training of between twelve and fifteen residents from the Peter Bent Brigham, the Beth Israel, and the Cambridge hospitals. The primary care program has been a source of great pride at the Medical School — rightfully so — and it is a program in which we have been an absolutely major participant.

We are particularly interested in beginning to develop some undergraduate Medical School courses that focus on primary care. There seem to be inadequate opportunities for medical students to learn some of the basics: decision making, decision analysis, skills in taking patient histories, and the general development of positive attitudes towards primary care. We have a committee trying to put together an undergraduate medical course offering. Thus far we have been much more effective at teaching interns and residents than medical students.

At present, we underwrite teaching in two different ways. First, we reserve one half of one percent of our premium income, about $250,000 a year, to support and stimulate teaching programs. Then we also stipulate that for all of our professional staff one half day per week is for teaching. So that every position has twenty-five days during the year which the plan explicitly pays for as teaching days. But those amounts of money and time aren't going to get us very far if we cannot be clever about how we teach undergraduate medical students in ambulatory settings. In the next decade we will have to face the tremendous challenge

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MITCHELL SPELLMAN, M.D. dean for medical services, HMS

Harvard Medical School's relationships with most of its affiliated institutions are based on understandings and traditions, many of which have no reduction to paper. Harvard does, however, have a formal affiliation agreement with the Harvard Community Health Plan. Signed on April 29, 1977 by Bob Ebert and Bob Biblo, the document first identifies and affirms their shared objectives, then distinguishes between the primary responsibilities of each organization — for HCHP, patient care and related endeavors; for the medical school, education and research — and finally stresses again their willingness and intent to cooperate and collaborate to the end that all of their institutional goals be advanced.

When the Harvard Medical Center was revived and reorganized two years ago, HCHP was admitted to membership. Within that organizational framework HCHP is the equal of, and functionally equivalent to, the hospitals, which are the best known and the traditional Harvard affiliated medical institutions. Harvard Medical Center and Harvard Medical School have no statutory authority nor any responsibility for the governance of HCHP, any more than they do for any of the other affiliated institutions. HCHP is a voluntary affiliate of the Medical School.

There was a lengthy discussion over a period of months in the councils of the Harvard Medical Center about the conditions under which a Harvard affiliate could adopt "Harvard" into its name. The first point of general agreement was that there ought to be an equal right and access to the name by all if such a privilege was given to any one institution. It was then recommended by the corporation that if an affiliated institution wished to take on the Harvard name, that the most appropriate way to do it would be within the context of membership in the Harvard Medical Center — and that the name ought to be a suffix; that is, the name should read the XYZ Institution in or of the Harvard Medical Center. This would serve to achieve some equity and uniformity and would avoid what had been the objection previously, that using it as a prefix would lead the uninformed to believe that institution was the only affiliated one, or the favored one, the one most deserving to bear the name. The trustees of the Harvard Medical Center accepted this recommendation. They also agreed that before the Harvard Medical Center would acknowledge the right of a member institution to take on the Harvard name, the corporation would have the chance to endorse and concur with the conditions by which that member would be assuming the name.

It was subsequently suggested to the chairman of the board of the Harvard Community Health Plan that HCHP examine this alternative as a way of conforming with the Harvard Medical Center policy that has now been accepted

A pattern of growth: in 1969, two floors of an apartment building were more than adequate for the eighty-eight members of the Harvard Community Health Plan. Seven years and 37,000 members later, the Kenmore Center had nearly outgrown its premises. In 1977 HCHP purchased and remodeled a nearby S.S. Pierce warehouse. The new center, dedicated in October 1979, has a membership of over 40,000 — and a capacity of 52,000.

by the other members. On the part of HCHP there has been I believe at least a willingness to consider the possibility of, for example, changing their name to the Community Health Plan of the Harvard Medical Center — although I don't think their discussions have gone so far as to consider what they might call themselves. In this situation it is important to remember that the actions of the Harvard Medical Center are usually by consensus, and even "binding" resolutions do not commit any institution to accept the risk of performing in the interest of any other. Each member is free to join or not to join a particular initiative.

Approximately two years ago HCHP adopted a policy enabling them to commit one and a half percent of their gross revenue to the sponsorship of education, research, and community service — one half percent to each of the three sets of endeavors. Last year the total came to about $600,000, and it is projected that this year it will be in the neighborhood of $750,000. These funds are cumulative. If not expended in their entireties in the course of a particular year, they are not allocated to some other set of programs. Dean Tosteson and I have met with the medical director, the president, and the chairman of the board of HCHP to discuss ways in which the Medical School's primary wish, to help strengthen education and research in HCHP, could be achieved with the allocation of these funds. A wide range of options have been suggested, including the creation of something called a professorial unit, which might comprise one or two or more persons holding senior professorial ranks who would be committed to programs of education and research in the setting of HCHP. At the other end of the spectrum of alternatives is the possibility that HCHP contract with the Medical School in some way by which the education and research services would be provided. If the former were undertaken, it would require formal searches similar to the kinds in which the Medical

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The tie that binds: The Harvard Medical Center

Formed in 1956 by the trustees of the affiliated teaching hospitals, the President of the University and the Dean of the Medical School, the Harvard Medical Center Corporation is an organizational mechanism linking the Harvard Medical School and its related teaching hospitals and health-care institutions. During the first 15 years, the Center helped raise funds to build the Countway Medical Library and endow several chairs for medical research. To meet the new needs of the member institutions, the Medical Center was reorganized in 1978 with the establishment of a Medical Staff Council and a Hospital Directors Council (both chaired by the Dean of Medical Services) and an Executive Group.

In this second phase the goals of the Harvard Medical Center are to provide a forum for exchange of information, to address issues and problems of common concern, and to advance teaching and research through collaborative efforts of the affiliated institutions. The Medical Center has undertaken a study of strategies and approaches to hospital cost containment; initiatives to improve coordination of graduate medical education; a search for procedures for systematic assessment of new medical technologies which can evaluate efficacy as well as costs, benefits, and means of financing; and development of positions on policy alternatives for compensation of faculty physicians who provide in-hospital services for private patients.

The Hospital Directors Council and the Medical Staff Council review planning issues; consider institutional relationships and cooperative arrangements; and, from their own perspectives, assess the impact of legislation and regulations on patient care, teaching, and research.

Presided over by the Dean of the Medical School, the Board of Trustees of the Medical Center includes the President of the University, and the chairmen of the boards of the other member institutions: Affiliated Hospitals Center, Inc. (Peter Bent Brigham Hospital, Robert B. Brigham Hospital, and Boston Hospital for Women), Beth Israel Hospital, Children's Hospital Medical Center, Harvard Community Health Plan, Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital/McLean Hospital, Mount Auburn Hospital, New England Deaconess Hospital, and Sidney Farber Cancer Institute.

While not formally members of the Medical Center, the Harvard University Health Services and the tax-supported hospitals and health facilities affiliated with the Medical School (Cambridge Hospital, Massachusetts Mental Health Center, West Roxbury Veterans Administration Medical Center, Brockton Veterans Administration Medical Center, and the Boston Veterans Administration Out-patient Clinic) participate in the activities of the Harvard Medical Center by invitation.

(From the Information Booklet 1979-1980, *page 105)*

SIDD

(continued from page 19)

Health Plan on a nine to five basis. Getting up in the middle of the night does become a chore after a while. But I hope that everybody will begin to appreciate what HCHP really is doing, just two hundred yards from my hospital and my office. Their new building is a very large medical facility that has cost seven or eight million dollars to build, a beautiful structure. It is my understanding that it will shortly be enrolling forty thousand patients — in the town of Wellesley, which has a population of about twenty-six thousand. It has a right to be there. It has a right to be successful. It does not have the moral and ethical right to have the name Harvard. I don't mind competing; that's the American system. But I really don't enjoy competing with the name Harvard. If I were a football player I'd love to play football, but I don't think I'd like to play against the Pittsburgh Steelers every weekend.

Several months ago a patient of mine, a very intelligent attorney, whom I've followed for the last twelve years of my practice, told me he was going to explore very carefully Harvard Community Health Plan's offerings. Keep in mind that HCHP is purely commercial; they advertise, they undercut Blue Cross-Blue Shield. They have a right to do this, but it is a commercial operation. What this attorney told me — I think my Harvard diploma was over my right shoulder — he told me, "After all they are a little less expensive than Blue Cross-Blue Shield, and after all they are Harvard Medical School. And that, I think, is the best medical care." This left me sort of speechless and really magnetized my concerns.

Once again, the issue should not be lost. HCHP has a right to be there, they have a right to be affiliated with the Harvard Medical School and help in the Harvard teaching program, but how they ever got the name Harvard and why Harvard allowed that name to be out there on a purely commercial competing organization, I'll never know. It is a mistake. At the Newton-Wellesley Hospital we have about fifteen or eighteen alumni of Harvard Medical School, and all of them are hurt. I would like to see my medical school face up to this issue, to have them look at it clearly. And if in fact the affiliation of Harvard Community Health Plan and Harvard Medical School is not that strong, then the Medical School should come out and say it. And, if nothing else, if Harvard Community Health Plan is going to keep this name, then at least make them take the pseudo logo off of their advertising. There's an awful lot that's going on here that's very subtle, and a lot that's not so subtle. □

The hospital on the hill: what was formerly the Parker Hill Medical Center (a 115-bed, private, acute care hospital) is now the home of HCHP's inpatient facility, renamed the Hospital at Parker Hill. A reflex hammer's throw away from the Medical Area, Parker Hill opened in October 1979 and, as described in a recent HCHP brochure, will "provide less expensive alternatives to the higher cost of care at teaching hospitals" for secondary medical conditions.

MOORE

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of how to support teaching and how in fact to conduct that teaching in a place where we cannot include the cost in a hospital bed day rate.

There is one other point, with regard to teaching, that I think makes our relationship with the Medical School very special. The last time I counted, there were eleven HMOs either in operation or being planned for the Greater Boston area. To my knowledge, none other than HCHP is affiliated with any Harvard institutions. BU is starting an HMO at Boston City and University hospitals, Tufts is planning one that will use the New England Medical Center as their tertiary institution and will use that school's community hospitals as the feeders. Bay State has its primary affiliation agreement with University Hospital; it has already begun to enroll members.

The government's stated policy is in fact to stimulate HMOs, and, as you can see from what's happening in Boston, they've been doing a very active job of it. I think Dean Ebert had immense foresight when he recognized that in the 1980s one of the major mechanisms by which patients would continue to flow into the hospitals of the Medical School would be through the marketing mechanism of a care service like HCHP. As a result of his prescience, we now have the foremost HMO in Boston and an opportunity in a marketplace that will be increasingly competitive to assure that the Medical School will continue to have a flow of patients for teaching its students in the future.

We use 360 hospital beds per thousand members per

year, or approximately one bed per day for each thousand members. We currently use an average of eighty-four beds on any one day. Some of those are in hospitals outside of this geographical area — emergency cases, automobile accidents, and the like — so our daily census in Boston area hospitals would probably be in the neighborhood of sixty to sixty-five beds. A very few of those are now at Parker Hill; in the next year or two, perhaps twenty-five percent of them might be handled at Parker Hill, and in the longer range future a bit more, but we would be very unlikely to get above fifty percent there.

Part of the drive to establish our own hospital came because we wanted to save money. We wanted a community hospital where we could control the costs and have a stronger influence over the quality of service. But another major motivation was the need to guarantee access to hospital beds. We were unable to do that as the membership grew because we have been shut out of a number of hospitals. Physicians of course have great power at hospitals, and one thing those of them who are against HMOs have done in the past is to unite to keep us out of hospitals we needed or thought we would need in order to continue to grow. A very good example of that is the Newton-Wellesley Hospital, which refused to let the Harvard Community Health Plan utilize medical and surgical beds, primarily because of pressures from the medical staff. The major impetus for acquiring Parker Hill Hospital came from not knowing how we were going to serve our members in the western suburbs. And if we don't service them, someone else will — the Tufts HMO, or BU's, or whoever.

It has been asked to what extent the inclusion of "Harvard" in our name has contributed to our success. Well, although the name has certainly been an asset in attracting the technical, professional elite, our marketing people suggest that it has been a very adverse factor in terms of marketing the plan to blue collar workers. We have done very poorly with that group; it seems that for some reason the lower and middle income people in Boston don't like Harvard. And in order for us to grow in the future, I would argue that one of the major sources of patient population we would like and need to draw into the Harvard Plan and ultimately into the Harvard Medical School orbit, would be the blue collar workers. I think our kind of plan works very very well for them and we would like to be able to serve them better.

I don't want anyone to feel like I'm saying, go ahead, take the name away. I like being called Harvard; I feel very much a part of Harvard and if it were taken away it would cause some bad feelings among our staff who would feel they were being kicked in the teeth. But it would not mean the end of the plan. It might, however, change the relationship of Harvard Community Health Plan to the Medical School. I think that if we didn't have the name Harvard there would be very strong reasons why the Medical School would be telling us to say we are the Harvard HMO, to go out and market that. The name identifies us, and it gives Harvard an opportunity to feel we're a part of it; the name pulls us in. From my point of view, strategically, on the part of the Medical School and the affiliated hospitals, that is an advantage. At one point we were approached by the New England Medical Center. They asked, what if we could give you a better price on your tertiary beds? Would you take your patients here? We said no. We said we are a Harvard institution.

I do not believe that the private practitioners who are objecting to the name Harvard are totally without cause. But their protests have to viewed from the perspective of whether we are fulfilling our mission to the Medical School as regards teaching, research, and patient service. Is the fact that we're called the *Harvard* Community Health Plan something that the Medical School can be proud of, or should they be unhappy about it? Are we sullying the name? In the dean's strategy, how important is it that there be an active and growing and vital HMO strongly affiliated with Harvard? Those, to my mind, are the relevant questions.

There is also concern about our plans for expansion. We're almost ready to open our center in Wellesley, and yes, we do intend to expand to the north and south as well, so that people in those areas will have access to the Harvard Community Health Plan. We are expanding in response to members who, in our surveys, asked us to open a center in Wellesley, and to open one in the north, and because we know that there are, let's say, a million people in the southern area that we could service. In addition, we spend lots and lots of time talking to doctors in the areas that we're thinking of moving into. I would say that in the first five years of the plan, we were absolutely not welcomed by them. In the second five years we still weren't exactly welcomed, but they were interested. Recently a surge in interest in HMOs has come about because a number of physician leaders in medical schools and community hospitals

The Corporation

Harvard Community Health Plan was established with the sanction of the administration and the eventual approval of the faculty of the Harvard Medical School. The plan's "Agreement of Association," signed on November 7, 1968 by the eight original members of the HCHP corporation, reveals the intended strength of the ties between the two institutions: "The primary purpose of the corporation is to join with the Medical School of Harvard University and its affiliated teaching hospitals to advance the development of comprehensive health care and to promote medical education by formulating a program or programs of prepaid comprehensive health services for a subscribing population." Furthermore, "upon any liquidation or winding up of the affairs of the corporation" — such a decision would require the approval of a majority of the members of the corporation — "its entire assets remaining . . . shall be conveyed, transferred, and set over outright to the President and Fellows of Harvard College to further the purposes of the corporation as herein stated." (The 1977 formal affiliation agreement between HMS and HCHP, described on page 20 by Mitchell Spellman, reaffirms and elaborates on the cooperative nature of the venture.)

Despite such implicit and explicit bonds, the organizational independence — administrative and financial — of HCHP was guaranteed from the outset. The interests of Harvard have always been expressed by virtue of ongoing representation of administration officials within HCHP's corporate structure.

Robert H. Ebert is recognized as the father of the plan, which was incorporated in 1968 and opened its first facility, in Kenmore Square, a year later. Ebert has been the chairman of the board since its inception. He shared his vision of a comprehensive prepaid medical organization — that would also become an academic testing ground for primary care — with Jerome Pollack, who joined the HMS administration and faculty in 1965 as the nation's first associate dean for medical care planning. Pollack served as HCHP's first executive director, from 1968 to 1970. Three other people played principal roles in establishing HCHP's credentials and aiding its growth: Robert Biblo, who directed the plan from 1970 until 1978; H. Richard Nesson, who assumed the position of medical director between 1967 and 1973; and Joseph L. Dorsey '64, who took over that post until 1979. The current executive director (now titled president) is Thomas Pyle and the medical director is Gordon Moore '64, previously the associate medical director of the Cambridge Center.

In order to be a federally qualified HMO, an organization is required to select one-third of its directors from the subscribers themselves; HCHP, which was certified in 1977, has always followed this dictate with regard to its thirty member board. The remainder of the slots are filled by leaders in the medical and business communities. Comprising the Harvard contingent, as such, are: David Hamburg, soon-to-be director of the division of health policy research and education; Andrew Jessiman, associate professor of medicine, Peter Bent Brigham Hospital; Henry Meadow, dean for special projects; Mitchell Spellman, dean for medical services; Warren E. C. Wacker, director of the University Health Services; and John W. Norcross '35 of Nashua, New Hampshire.

There are ten members of the HCHP corporation (the number has fluctuated between eight and eleven over the years); their terms are self-perpetuating. The corporation's primary purpose is to formulate and amend the bylaws as well as to nominate and elect the board of directors. The present membership consists of: Derek Bok, president, Harvard University; Francis Burr, Ropes & Gray; F. Stanton Deland, Jr., Sherbourne, Powers, and chairman, Brigham and Women's Hospital; John T. Dunlop, professor, Harvard Business School; Robert H. Ebert, M.D., president, Millbank Memorial Fund; Martin S. Klein, president, Institutional Strategy Associates; Sidney Lee, M.D., associate dean, Faculty of Medicine, McGill University; Henry Meadow; H. Richard Nesson, M.D., director, ambulatory services, Peter Bent Brigham Hospital; Alan Steinert, president, Eastco Distributors; and Irving Rabb, vice chairman of the board, Stop and Shop Companies, Inc.

have moved from trying to stop HMOs to recognizing that they must be competitive with them. This is not surprising. It is exactly what the government wanted; it's what the HMO bill of 1973 attempted to do, explicitly.

There is another reason why we need to continue to grow, beyond what I've already mentioned. The reason is somewhat complicated; it has to do with the dynamics of the business of an HMO. When HMOs start, they tend to attract young patients who do not have physician affiliations. Then, as the HMO ages, the patient population also ages. And if an HMO stops growing and there is competition in the marketplace, the new HMOs will attract in the younger patients and their premiums will be low and they will erode your marketplace because your patients have gotten older. I've said that we use an average of 360 bed days per thousand per year; by the time those members are sixty-five they'll account for 1400 bed days per thousand per year. It's not a single step function, it's a continuous slope. If we stop growing and just watch our existing members age, we will price ourselves out of the market. Because there is competition. Otherwise we'd be perfectly happy, we'd just pass along the increasing costs in the premium. And if the members, most of whom are very happy with an HMO, had no alternative HMO to go to, they would probably stay with us and pay the extra premium. But there, precisely, is the logic of the government's argument. We have to compete on a price basis, and part of that competition, just as it is in business, involves getting what's called marketplace share. In order to survive on a financial basis we do, in the short term, have to continue to grow. If we don't, then we can't compete. If, say, the Harvard Community Health Plan was to fold tomorrow, there is no way that all eighty-three thousand of our members would continue to come to Harvard hospitals. Of the sixty beds that are now used for hospital teaching, I'm sure at least half would go elsewhere. □

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After a rather one-sided correspondence with the dean regarding this issue of the name I was honored with a reply. Included in it were some faculty council minutes from April 13, 1979. At the Faculty Council meeting, Dr. Gordon Moore — whom I happen to know and like and respect — gave a very long presentation on the history of the Harvard Community Health Plan. Near the end of the presentation was something which I think bears very significantly on the question at hand: "Dean Tosteson then raised a question which had not arisen in previous discussions, the issue of the name. 'In terms of the formal legal relationship,' he said, 'the most accurate analogy is with the other affiliated hospitals — is it appropriate that only one of the institutions bears the Harvard name?' He noted that although HCHP is a totally independent corporation, there are a significant number of Harvard representatives on the HCHP board, and the rules regarding the board's composition ensure a continuing Harvard influence. Dr. Lawrence added that the Dean of the Medical School or his representative sits on the nominating committee for the medical director of HCHP. One faculty member replied that the decision to permit the Plan to use the Harvard name seems useful and appropriate to him, as that name had been necessary to enable HCHP to get started successfully. The need seemed an adequate criterion."

I would like to point out the illogic of this. Here is a totally independent corporation, in business for themselves, making profit for themselves. Let's draw a different analogy. Consider a multi-specialty group, or a group of doctors of one specialty, say, renal disease. They decide to open a dialysis unit and call themselves the Harvard Dialysis Unit, or the Harvard Internal Medicine Specialists, or the Harvard Group Practice of Downtown Boston. Think about the impact and the influence this would have on the community. There is now — as anyone who lives in this area knows — continual confusion regarding the Harvard Medical School and the Harvard Community Health Plan. I'm a baseball fan, and during the season I get off the "T" at the Fenway stop. As I then pass by the colossal Harvard Community Health Plan structure and listen to my fellow baseball fans, I hear them say, "What's this?" "Oh, this is the new Harvard Medical School building." "Well, are they going to admit their patients here?" "No, their patients will still be admitted elsewhere, but this is where all the Harvard Medical School doctors will be working." My point is that many people assume that the two things are synonymous.

If a group of cardiac surgeons on the faculty of the Mass. General or the Peter Bent Brigham wanted to open up a practice outside of those hospitals, and wanted to call themselves the Harvard Cardiac Surgeons, would their institutions allow them to do so? They would not. But the Harvard Community Health Plan is being permitted to do exactly that. They're plopping down fifty-five doctors into a community which is not in need of doctors, which in fact is one of the most highly sophisticated medical communities in the world. The net effect of this is to disrupt the ordinary lines of practice. It won't drive me out of practice, but it's going to dissuade any other doctors from coming into the community, and it's going to diminish the chance for successful private practice there. It will become a self-fulfilling prophecy as fewer new internists and subspecialists come in, and more and more people find the option of the Harvard Community Health Plan attractive. These are generally white collar, professional, intelligent people, many of whom are Harvard College graduates — and many of them think they're getting Harvard with HCHP. They look at HCHP's advertisements and they think they see the Harvard logo. If you look closely you see that it isn't that, really, but it's a crimson shield that looks just like the Harvard logo, except without "Veritas."

The HCHP brochures claim that its patients are admitted to the Mass. General, the Peter Bent Brigham, the Beth Israel, and the Mass. Eye and Ear. In reality, while it has some people on each of those staffs, most of the care is delivered at the Cambridge City Hospital, and soon will be delivered at the Parker Hill Hospital. In the last six months there has been a drop in the admission of HCHP patients to the hospitals I just mentioned, because HCHP is opening its own facility at Parker Hill. They will be transferring their uncomplicated, routine adult admissions to the Parker Hill Hospital. That is simply what is going to happen — although they say their relationships with the tertiary care hospitals won't be affected.

But HCHP is drawing further and further away from the traditional Harvard hospitals, and at the same time making a very strong statement about their deep commitment to teaching and research. According to Gordon Moore, they have made the decision to put one half of one percent of total patient income into teaching, and one half of one percent into research. (Think about the percentage of your own time that you really devote to teaching and research and see if it comes up to their standards of one half of one percent of your time with patients.) They also have statistics that say that something like seventy-four percent of HCHP physicians are involved in teaching house officers — but that's not necessarily Harvard house officers, and some of the teaching itself is suspect. When they employ someone that person is supposed to give a half day a week for teaching. In reality — and I know this for sure because I moonlighted there some years ago — people don't use that half day a week to teach.

HCHP has two medical residents from the Brigham who rotate through, and they plan to have a couple of surgical residents from the Brigham as well. And at least when I was there they had some primary care doctors from the Mount Auburn and the Cambridge City that went through. But this is not a strong teaching affiliation. It is a weak affiliation, used primarily to keep down the cost of the HMO. The HMO reduces its costs by lowering hospital utilization and by relegating responsibility to nurse practitioners and other people — including residents — who, in the place of fully trained doctors, see many of the patients there. In this way, HCHP obtains much more from the residents than vice versa.

I want to go back to what the Harvard faculty member said in the Faculty Council's discussion of HCHP. He said that the use of the Harvard name seemed useful and appropriate because that name had been necessary. Need seemed an adequate criterion. So what he was saying is that expediency dictates morality. When from time immemorial that's not been sufficient reason; that's never

The baseline statistics

How much *Harvard* is there in the Harvard Community Health Plan? The figures and facts which follow were taken from Dean Spellman's address to the Alumni Council and from the 1979-80 HCHP annual report.

■ In the current fiscal year, HCHP has employed between 130 and 140 physicians. Approximately eighty-six percent of these hold Harvard Medical School faculty appointments, and thirty-four per cent are HMS alumni/ae. Overall, 21.3 percent of HMS faculty members with the rank of assistant professor or above graduated from the Medical School (306 out of 1438).

■ Seventy-two percent of the HCHP physicians teach medical students, and seventy-four percent teach residents in the Harvard teaching hospitals. Under ordinary circumstances an HCHP doctor visits in one of the hospitals approximately two months of each year; during that time he or she contributes an estimated ten hours per week to teaching.

■ During the last fiscal year (October 1978 through September 1979), there were opportunities for a total of sixty-nine to eighty-seven medical students in preceptorships and clerkships at HCHP: places for twenty-seven to forty-five third and fourth year students in HCHP family practice preceptorships (three to five in monthly rotations at the Cambridge center); advanced clerkships in internal medicine for eighteen fourth year students (two per month at Parker Hill); and pediatric clerkships for twenty-four second year students (twelve each at the Cambridge and Kenmore centers).

■ Last year, HCHP contributed to the support of twelve primary care internal medicine residents from the Beth Israel, the Peter Bent Brigham, the Mount Auburn, and the Cambridge hospitals. Beginning in July 1980 there will be two additional residents from the BI. These trainees spend the half of their time that is devoted to ambulatory patients at one of the HCHP centers. There are seventy primary care residents in the Harvard system; thus HCHP provides about twenty percent of the Harvard resources committed to the ambulatory component of primary care residencies. The seven full time equivalent (FTE) positions are underwritten by HCHP. In the coming year HCHP will also underwrite four-and-one-half other FTEs for residents: one in ambulatory surgery, affiliated with the Peter Bent Brigham; one each in dermatology, ob/gyn, and orthopedics, all in association with the Beth Israel; and one-half in ambulatory pediatrics, shared with Children's Hospital.

■ All medical and surgical residents at the BIH and the PBBH can spend from a month to six weeks of their training in rotations at Parker Hill, in the setting of a community hospital. All BIH residents, all PBBH surgical residents, and most PBBH medical residents particpate in the program.

■ During the fiscal year that ended in October 1979 approximately 5200 HCHP patients were admitted to the Harvard teaching hospitals; about 440 were referred to other hospitals. For the current year HCHP projects the admission of 6000 of their patients to Harvard hospitals. They again expect that number to comprise about ninety percent of their total patient referrals.

been a sufficient criterion in politics, in religion, in history. Need is simply not enough. There has to be a better reason than that. It is interesting to note that the same faculty member said that he saw no virtue in consistency with regard to permitting one or another of the Harvard affiliated institutions to use the Harvard name.

It has been predicted by some that by the middle of this decade ten percent of the people in the Commonwealth of Massachusetts will be enrolled in HMOs. Harvard Community Health Plan is presently the largest HMO in the state, and they believe they will have more than a quarter of a million members enrolled within the next few years. I am not here to argue the merits of HMOs, although I do have my own particular ideas about whether they provide better or worse medical care. But regardless of how I feel about that, HCHP has been extremely successful. And the HMO may be the way medicine should be practiced five or ten years from now. The issue here, however, is whether this group should be allowed to use my name and your name. I obviously feel that they should not be. I just hope that if they do win out in the marketplace, they won't do it with the name Harvard. □

SPELLMAN

(continued from page 21)

School and affiliated hospitals collaborate to find incumbents for the tenured positions that are hospital based. No decisions on these questions have yet been reached.

The community service funds, although they do not bear directly on medical education and research, are certainly health-oriented. For example, although the Mission Hill Clinic — for economically disadvantaged residents of that area — is largely supported by federal grants, HCHP does contribute something like $50,000. It has also underwritten other kinds of community service programs in which outcomes or objectives are designed to improve the health of the public.

It is important to recognize the growth capacity of this commitment of HCHP money, as well as to understand that it does not underwrite all of the educational programs supported by HCHP. Of the operating budget this year something like sixteen million dollars will be allocated to Harvard hospitals for patient care — thus in effect supporting hospital-based educational programs. Add to that the direct expenditures out of operating revenues for graduate medical education and you end up with a sum significantly larger than the one and a half percent figure. □

The Alumni Council Debate: June 3, 1980

The following is a portion of the discussion in response to Dean Spellman's Alumni Council presentation. (Doris Bennett '49, Council treasurer, is chief of pediatrics at the Kenmore Center and chief of the Mission Hill Center of HCHP.)

GORDON DONALDSON: Has there been any discussion within the governing board of Harvard Community Health Plan about changing the name? They're aware of the pressures certainly.

MITCHELL SPELLMAN: There has only been a discussion between Dan Tosteson and Bob Ebert. I'm not aware of anything beyond that.

DORIS BENNETT: I don't see how we would do it. How would we tell 100,000 subscribers that we have to drop this name? I don't think it would make much difference. My patients don't come because of the Harvard name, they come to see me. In recruiting new members, possibly, yes. But even so, knowledge of us has spread to the point that I'm not sure that dropping the name would hurt us that much. And I can't see how we would do it with all the publicity that would be attached.

PERRY CULVER: Suppose you changed the name to the Community Health Plan of the Harvard Medical Center.

DORIS BENNETT: I think that's worse . . . for Harvard. It would sound as though the Harvard Medical community had actually taken us in and were sponsoring us.

MELVIN OSBORNE: It's only fair to state that the common belief is that Harvard Medical School runs this program. At least the doctors around the community feel that way and I think the patients do too. We know HCHP is an insurance company, it's quite large, it's growing rapidly. But people would like to know its governance, its quality control, and its real relationship to the Medical School.

PERRY CULVER: There's another perception that I hear, at least further down the river. Many people at the MGH think of HCHP as having no relationship to Harvard whatsoever; they feel it's an autonomous organization that is capitalizing on the name Harvard and threatening other kinds of practice. It becomes a very emotional issue.

DORIS BENNETT: If we change the name we're going to be just as threatening to these people. They have picked upon the name as a focus of their anxiety about us taking away their patients.

CARL WALTER: You have to go back in history and realize where the umbrella came to shelter this fledgling until it got going. That's why the 1600 alumni within 495 are resentful. Everything was done secretively. And if you only stopped this comparative advertising, two-thirds of the problem would go away.

DORIS BENNETT: Blue Cross is advertising too. They're going to open an HMO on the South Shore. They're going to be just as much competition as we are. And they're doing it to compete with us. What these doctors have to do who resent us is compete with us. Everybody's sitting back on their laurels and charging what they want and letting medical costs go way up. We are trying to bring down costs. Dean Ebert's idea when he founded us was that we were going to produce healthy competition in the medical field, which is very necessary.

JANE SCHALLER: Using the name Harvard implies that there is some kind of rather rigid quality control. If you're going to work at the MGH you've got to be good and if you're going to get an appointment at Children's you've got to be good. There's some sense that just about anybody can get hired — and I don't say that in a bad way — by the Community Health Plan whether or not they went to HMS or are particularly good. There's that connotation to the discussion.

DORIS BENNETT: Sure. People are saying that because that's what they want to think. It's very hard to get a job at HCHP. You have to have very good qualifications.

JANE SCHALLER: There's also the feeling that this organization is going to go on in uncontrolled growth and spread out and engulf the entire country, probably ending up in Seattle.

DORIS BENNETT: I'm not against fee-for-service. It is still going to comprise ninety percent of our health care. But HMOs help to make the fee-for-service sector more cognizant of cost containment issues. Now Harvard can be in the business of writing legislation and of promoting alternatives in health care delivery or it can be in the position of sitting back and reacting to whatever happens.

GORDON DONALDSON: This group could do that without the name of Harvard tagged on, couldn't it?

DORIS BENNETT: Oh, we could now. I think in retrospect it is very unfortunate that Dean Ebert and his colleagues decided on the name Harvard Community Health Plan. Yet that has been its legal, incorporated name for twelve years. It could only be changed voluntarily.

GORDON DONALDSON: I want to read one paragraph from one of the plan's critics: "When HCHP was formed, alumni were told two things: first, that the Medical School would have a major voice in controlling the policies and functions of the organization and second, that the service area would be only those areas of Boston that were physically contiguous to the Medical School or particularly undoctored." Is that true?

DORIS BENNETT: I never heard that. For us to take only patients who live near the Medical School would not make sense.

PERRY CULVER: When this plan was originally debated in the faculty there was quite a lot of effort to try and sell it. Statements like that were made to win the faculty's approval. There was grave concern with respect to just exactly what this plan was going to do and how it was going to be managed and so forth.

MITCHELL SPELLMAN: The growth of HMOs affiliated with medical schools is occurring everywhere — here, Minneapolis, Washington, D.C. If we can move toward recognition and a definition of the role and relationship of HCHP in which it functions truly as an affiliated hospital and becomes not only a responsible but I would say a significant underwriter of education and research, that would be an impressive gain. $750,000 a year committed to education and research and perhaps eventually one million dollars a year (which could endow a new chair every year) is a sum, as well as a policy, to be reckoned with. Of course hospitals fund chairs, so I'm not saying that this is comparable, but it's a

A loss for family practice

Things will get worse, it seems, before they get better for devotees of family practice in the Boston area. In a memo dated June 4, Dr. Burt Johnson, director of the Cambridge Center of HCHP, informed all Cambridge members that the family practice department at the center would be eliminated at the end of the month: "After a five year existence . . . a series of events and circumstances have led to a decision to end family practice as a separate entity. Given that the future role of family practice within HCHP is currently uncertain, the decision by Dr. John Whyman to transfer to the internal medicine department at Wellesley, the unfortunate, extended medical leave of absence required by Dr. Carl Brandfass, and the resignation of Dr. Hank Cohan makes the closing of the department the only reasonable option."

Editor's note: Johnson was on vacation when the Bulletin *went to press, and thus was unavailable to elaborate on the "currently uncertain" role of family practice within HCHP, or to discuss the implications of this development with regard to medical education at HMS. A full report will appear in a forthcoming issue.*

beginning. The Medical School would be well served by urging and indeed insisting that as an affiliated institution HCHP strengthen and support education and research.

JANE SCHALLER: Do any of the HMOs associated with medical schools carry the name of the school?

MITCHELL SPELLMAN: Yes, but they bear a different relationship. George Washington University HMO is part of the George Washington Corporation. George Washington owns their own HMO, if you wish to look at it that way, which operates within the George Washington Hospital. It is a faculty-intensive HMO in that all of its members are full-time faculty. It would be useful to remember also that George Washington University subsidizes this HMO on the order of about $200,000 a year.

CARTER ROWE: What about Tufts Medical School?

MITCHELL SPELLMAN: Tufts is in the process of organizing one; I don't know what it's going to be called.

DORIS BENNETT: They're calling it the Tufts University Medical School HMO. And BU is establishing one that will have its name.

WILLIAM CHRISTENSEN: There are two questions that intrigue me. In the half-dozen letters I have read from estranged alumni it seems that only the elimination of the name Harvard would make this situation palatable. There's no suggestion that a change in governance or in selection of personnel or in modus operandi would do it.

GORDON DONALDSON: I would agree one hundred percent.

CARL WALTER: The people that have been bugging me are afraid of the boogey man aspect of it. It's like MASCO, like MATEP — all done sort of undercover. It's awful hard to fight a feather pillow and that's what they think they're doing.

GORDON DONALDSON: I don't think the alumni are afraid of HMOs. I've received three or four letters that have said they're not bothered by the fact that HMOs are springing up. After all, we're all going to be working for HMOs someday.

WILLIAM CHRISTENSEN: What we're seeing are the beginning manifestations of a severe competitive problem in American medicine. In the state of Massachusetts now I believe the figures are one physician per 350 people. One of the lowest ratios in the U.S. As I look at this, they have touched all the bases. They are a member of the Harvard Medical Center and HMS officials are part of their structure. We cannot deny them the opportunity to use this name. A Philadelphia lawyer couldn't take it from them.

DANIEL FEDERMAN: There are several layers of meaning here. First, solo practitioners have fought group practice since group practice was invented. Second is the growth of competition from a specific entity that has reached out in an aggressive, advertising way that the individual physician is unable to match. This is an irritation as the market gets tighter. Third, doctors are concerned about the potential displacement from hospital privileges. If a group of the size and clout of HCHP gets into a new hospital, the individual practitioner at that hospital could be jeopardized. Now that's a consideration that may loom as a problem in five or ten years, but it's still ahead.

DOUGLAS COLLINS: This group is doing what is so characteristic of doctors. They're attacking something that is growing and that they can't stop instead of proposing a solution that would be constructive. I identify with the solo practitioner and yet I think that Harvard Community Health Plan is a wonderful thing and I support it. We should see both sides. We could point out to them that changing their name could be a tremendous advertising gimmick. When Esso changed to Exxon they made money on that the whole way. I remind you that people are used to talking about "The College," and we might suggest to HCHP that they call themselves "The Health Plan." Think of the advertising mileage.

DANIEL FEDERMAN: A number of letters from alumni have routinely asked about the role of HCHP in teaching at Harvard. We should put some weight on their medical student teaching which, specifically, needs to be much expanded. That I consider their big sin.

DORIS BENNETT: We have wanted medical students. Four or five years ago a professor of pediatrics came over to see us. She looked around, saw what we did and said she could teach medical students in twenty minutes everything we had to teach. And we didn't get any. This year we have had about thirty and I must say they have all written us letters of appreciation. Don't say it's our big sin. Because it's not mainly us. It is partly us, I agree, but the Medical School didn't think we were good enough to have students.

DANIEL FEDERMAN: That is another question. I want to make a positive statement. The figures being bandied about are $500,000 or $600,000 coming back to the school. In terms of Harvard endowment and pay out that's a gift of ten million at five percent. At a million dollars it would be a gift of twenty million dollars. Carl has emphasized the switch to yearly giving rather than endowment and if one is trying to put it in perspective, those figures are very large amounts of money. At ten to twenty million dollars maybe the Medical School should change its name. □

Family practice matters

I read with alternating enjoyment and exasperation your issue on "the generalist in 1980." As a once-and-future family practice resident, married to a Harvard Medical School classmate taking the internal medicine route, I thought your treatment sidestepped one glaring issue. It also failed to emphasize some cross-disciplinary answers to why more of us don't do primary care.

First, the issue: family practice versus the internal medicine/primary care track. The *Bulletin* bowed briefly to family practice by including two pieces by Harvard family practitioners: a non-political one on personal style by my own teacher Lucy Candib, and a lament by Karl L. Singer on Harvard's absence of interest in family medicine. Meanwhile, in the lead article, Robert S. Lawrence spends a few paragraphs at the end of a paean to Harvard's various primary care programs to point out their problems: many graduates are dissatisfied with their experience on primary care teams, and — more to the point — many of them go on to specialty training.

Why not have taken it the logical step further, and addressed the debate on whether family practice or primary care programs are more likely — or competent — to produce generalists? Primary care programs are Harvard's peculiar answer to the need for general practitioners. But as Candib and Wheeler point out in the letters section, some Harvard graduates have gone the way of the rest of the country — family practice. Why not ask their reactions to their training programs, and profile their practice patterns? Some, like the primary care residents, may have been sidetracked into public health or policy careers — but I guarantee you won't find many subspecialists.

The intellectually honest approach, both for the magazine and the Medical School, would be to explore the advantages and disadvantages of both kinds of training, rather than promoting one while denying the other's existence. Curtis Prout's reply to Candib and Wheeler's letter says it all: yes, he says, he knows there are family practice programs in New England, but alas, none of them are affiliated with *Harvard*.

It struck me that many of the reasons a lot of us do something other than primary care have little to do with the content of our training programs. They're audible in the comments of the residents you interviewed: "To see patients for forty or fifty hours a week . . . would be very draining." "Medicine isn't my whole life." "I would rather not be tied to a situation where I am the sole purveyor of care." These are the same feelings I encountered among my fellow family practice residents. The desire for a varied life, and the fear of isolation and "ultimate" responsibility cut across all of medicine. Apart from the lure of another credential (which might land one a job in New York or Boston), specialty fellowships attract because they offer the apparent safety of a smaller, more secure arena of knowledge.

If medical educators really want to produce generalists, what they must sell is the intellectual and emotional satisfaction — let alone the possibility — of doing a good job in general medicine. What they must vanquish is fear of isolation, boredom and overwhelming responsibility. Turf battles between medicine and family practice seem to ignore these problems, which are common to both.

Susan M. Okie '78

The latest *Bulletin* reports that considerable effort is being made by the school to direct students into general practice, but without notable success. The candidate often sets out with high purpose, then falls into the wayside of a subspecialty.

A simple solution must have occurred to many readers — pay the generalist as much as the specialist. This has worked quite well in other countries.

I discussed this problem with the chief of surgery in a large Norwegian regional hospital. In his area there was no problem in finding enough generalists; in fact, many of his highly trained specialists had left the hospital for this field. He added, "Of course they make very good money. Some earn much more than I do. And why shouldn't they? Those fellows are out there at all hours and in any kind of weather, sorting out cases for me. Look at my lap of luxury, a house staff, every convenience and relatively easy hours."

A remark by Adam Smith about butchers some two hundred years ago might well be paraphrased to describe the issue: it is not through benevolence that doctors make housecalls, but from their self-interest.

Rolf Lium '33

Harvard Medical School currently has one of the nation's best training grounds for family practice. Those physicians who obtain experience in the Harvard services of medicine, pediatrics, surgery, obstetrics and gynecology will find themselves well disciplined and fully prepared for the role of general family practitioner.

How unfortunate it is that Harvard cannot bring itself to help fulfill the most pressing of current medical needs, a return to the family physician. That an assistant professor of medicine, not family practice, directs its undergraduate primary care program only further highlights how poorly prepared Harvard is to meet the new challenge of providing some ten thousand generalists in the next decade. Internists, unfamiliar with the pediatric, gynecologic, and surgical needs of their patients, cannot fully meet the need for family practitioners, whose experience can be as broad as it is deep.

Harvard Medical School has a responsibility to aid, not hinder, the growing movement for cost effective family practice. A new family practice residency could be easily established with the help of the current residency directors. While family practice remains a non-entity at Harvard, I can only assume that political motives and fragile egos in this great medical school rule over those rational individuals who seek to deliver the best medicine to the greatest number at the lowest cost.

Despite the absence of a formal family practice department, Harvard Medical School and its residencies were able to prepare me for general practice. Following excellent training programs in pediatric medicine and obstetrics and gynecology, I fortified my bank account and honed my clinical tools with two years of emergency room and outpatient medicine. Then I stepped forth into the world of private practice. Within ten months of my recent entrance into family medicine, I had opened two offices in middle class communities. Soon, I will need associates to help serve the many people coming to see me after their years of frustrating dealings with the overspecialized. I feel I have gained the respect of my fellow physicians, specialists and generalists alike.

It's time for Harvard Medical School to turn out more Boston-trained family physicians. I can personally vouch for their utility and need.

Bruce Barnett '75

We want to correct one point made by Karl Singer in his article on the status of family practice education at Harvard (*HMAB*, April 1980) — his reporting the demise of the Family Health Care Program.

In fact the Family Health Care Program does exist and continues to provide a focus for family practice teaching at Harvard, as it has since its founding in 1954 as a pioneering venture in medical education. This focus, small as it is in comparison with the School's present major effort in primary care internal medicine, is nonetheless important for students at a time when family practice is the second leading career choice nationally and the major supplier of primary care physicians.

A strong argument can be made on educational grounds that all students should understand the role of the family doctor whether or not they choose this career, and that all should have an exposure to decide whether or not they wish this career. This ideal is not being realized at present. In our opinion we are seriously letting our students down.

Nevertheless, they still seem to fight their way upstream to become family doctors. In the graduating class of 1980, for example, nearly as many students selected residencies in family practice as in pediatrics, despite a lack of comparison between the educational resources committed here to the teaching of these two fields. These students formed their own support group to overcome the isolation they experienced in exploring the family practice choice.

The Family Health Care Program is now housed in the Family Practice Group of Cambridge, to our knowledge the only full service (one doctor for a family, pregnant or otherwise) family practice in metropolitan Boston. There are two board certified family physicians in the group and a third is being recruited. Educational activities are supported by an endowment given to HMS by the Theodore Schultz Fund.

The Program's many graduates will be happy to know that we are still in business.

Richard I. Feinbloom, M.D.
Director,
Stanley E. Sagov, M.D.
Associate Director,
Family Health Care Program

Lunch and the married man

The Vanderbilt Hall issue stirred memories of year gone by and calls for a bit of transition history through which a few of us lived. Perhaps this should become part of the record of that magnificent old barn.

Returning from World War II, and entering in the fall of 1946, were a few of us who presented the Medical School with a new problem — we were married, some of us already with children. The GI bill didn't really support us the way we had expected, so to make ends approximate (they never met!) we carried our lunches and thus became probably the first regular brown baggers in the history of the school. The most logical place to eat was in whichever amphitheatre we found ourselves at noon. This was a pleasant break, allowed new and long lasting friendships to form, and continued for some time until one day when we were unceremoniously kicked out, advised that Harvard did not permit eating in amphitheatres. In the summer we could eat in the quadrangle, but where in the winter? There being no answer to that question a group of three of us — Hannas, Patterson, and Coe, I believe — made an appointment to see Dean Worth Hale. All three of us had been in combat, but nothing we had lived through approached the terror of facing the dean. We presented the problem as best we could, he listened curiously, then leaned back in his chair, dismissing us with the comment, "Gentlemen, Harvard has never had a problem like this before." This apparently represented his final solution as we heard nothing further. Some time later, with no help forthcoming, we again bearded the dean in his cage, this time with the cold of winter adding an urgency to our approach.

Shortly after that meeting we were summoned by Dean Hale, who took us to Vanderbilt, introduced us to the long closed Deanery and gave us some of its history. It was, as you described, an abomination. We set to work, cleaned it adequately for our lunch time and study use, and for the rest of our time at HMS, the Deanery remained a private and pleasant rendezvous spot for the married group with their thermos bottles, brown bags, and crib boards.

Thus, in the fall of 1946, Vanderbilt Hall, with the dean's help, solved the first problem presented by the married student.

Robert C. Coe '50

Advanced sign

The photograph of the 1954 renal transplantation team in the Fall 1979 issue depicts yet another way in which Harvard was ahead of its time: the "NO SMOKING" sign, a rarity in hospital departments then.

Stanley P. Bohrer '58

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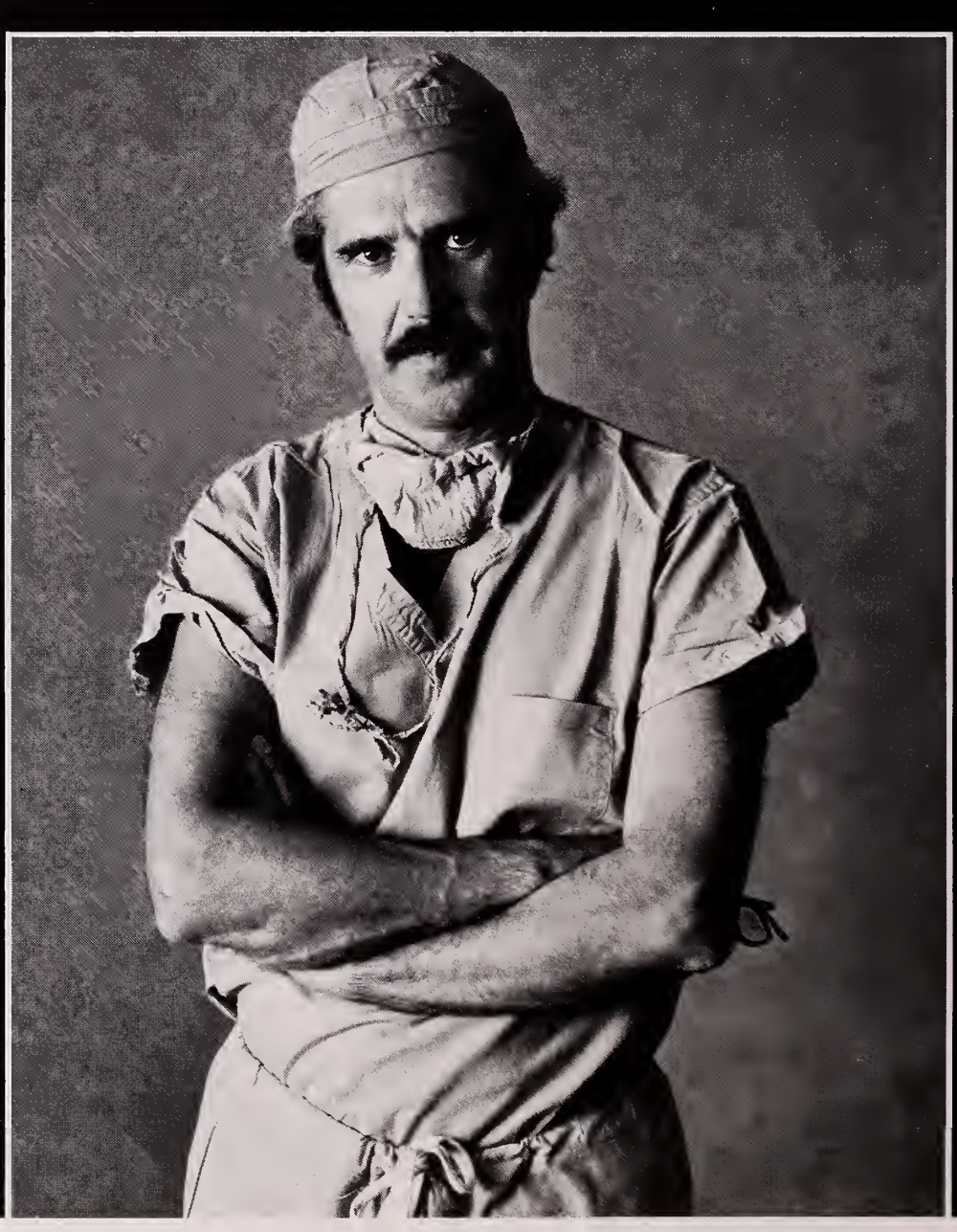

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